State of California Department of Health Services

APPROVED AMENDMENT

to the

CNETERS FOR MEDICARE & MEDICAID SERVICES
HOME AND COMMUNITY-BASED SERVICES WAIVER

for

IN-HOME MEDICAL CARE

Control Number 0348.90

Effective July 1, 2005

Waiver Term: July 1, 2003- - June 30, 2008

To the Secretary
of the United States Department of Health and Human Services
in accordance with
Section 1915(c) of the Social Security Act

IN-HOME MEDICAL CARE
Home and Community-Based Services Waiver
Control #0348.90

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SECTION 1915(c) WAIVER FORMAT

1. The State of California (State) requests a Medicaid home and community-based services (HCBS) waiver under the authority of Section 1915(c) of the Social Security Act (Act). The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.____ Yes b.__X__ No

   If yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a.____ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.____ Nursing Facility (NF) level of care (adult and pediatric)

   b.____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c.__X__ Hospital

   d.____ NF (served in hospital)

   e.____ ICF/MR (served in hospital)

3. A waiver of Section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a.____ aged (age 65 and older)

   b.__X__ disabled

   c.____ aged and disabled

   d.____ mentally retarded

   e.____ developmentally disabled

f.____ mentally retarded and developmentally disabled

g.____ chronically mentally ill

4. A waiver of Section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

   a.____ Waiver services are limited to the following age groups (specify):

   b.____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

   c.____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general nursing facilities, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

   d._X_ Other criteria. (Specify):

   The following additional criteria will be used to limit individuals who will receive services under the waiver:

   This waiver will serve physically disabled Medi-Cal beneficiaries, who would, in the absence of this waiver, and as a matter of medical necessity, pursuant to Welfare and Institutions (W&I) Code, Section 14059, meet criteria for care in a hospital for at least 90 consecutive days. Beneficiaries to be served under this waiver would have substantial care needs over a 24-hour period and would require the presence of a licensed nurse to provide periodic assessment and interventions, based upon a prescribed Plan of Treatment, for the following conditions;

   1. Traumatic or acquired neuromuscular impairment.

   2. Complex debilitating illness.

   In addition, the beneficiary shall have three or more of the following:

   1. Dependent on life-sustaining medical technology for more than 50% of the day.

   2. Total Parenteral Nutrition (TPN) at a minimum of three (3) times a week.

   3. Daily tube feeding (nasogastric or gastrostomy).

   4. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or daily IV drug administration via a peripheral and/or central line without continuous infusion.

5. Two or more medical treatments every shift with a minimum of six (6) treatments per 24-hour period (i.e. respiratory treatment, wound care, intermittent catheterization, ostomy care, tracheostomy care).

6. Need for a licensed nurse assessment at a minimum of every eight (8) hours for the administration of *Pro Re Nata* (PRN) medications.

In addition, all requests for IHMC Waiver services shall meet the criteria set forth in Title 22, California of Regulations (CCR), Sections 51344 and 51173.1, as appropriate.

IHMC Waiver services will be provided in a beneficiary's or primary caregiver's own residence, which is not a licensed health facility. However, if the home setting is not medically appropriate or available, the place of residence may include congregate living situations or facilities licensed as congregate living health facilities (CLHF), pursuant to Title 22, CCR Section 51173.1.

If it is determined that a recipient receiving IHMC services no long meets the above described enrollment criteria, the individual will be evaluated for a determination of the appropriateness for transition to either the Nursing Facility Level A and B (NF A/B) Waiver or the Nursing Facility Subacute (NF SA) Waiver. Any transition is conditioned on the determination that an individual meets the specific criteria described in the respective waivers.

Individuals served under this HCBS waiver will need to have an identified support network system to be available to them in the event the HCBS provider of care services is not able to provide the total number of authorized hours. The support network system could be comprised of available supports such as care providers, community-based organizations, family members, friends, etc., to assist the individual in the event the authorized care providers under this waiver are not available to render care in the amount approved by Medi-Cal Operations Division, In-Home Operations (MCOD-IHO). The identified HCBS waiver case manager will assess for the availability of this support network system at the onset of services and periodically as set forth in the POT and in accordance with IHO Case Management Acuity Program, but no less than once a year. In the event, the beneficiary does not have this support network system or if changes are needed, the HCBS provider of services will assist the beneficiary in developing and/or maintaining this support system. MCOD-IHO will also assist, as warranted, in the identification of supports needed to ensure the health and safety of the individual while under this waiver. To the extent that a support network system cannot be identified and/or implemented to ensure the health and safety of the individual, waiver services will not be authorized and the beneficiary will be notified in writing of their rights to appeal this determination.

IHMC level of care waiver services will be provided in a beneficiary's or primary caregiver's own residence, which is not a licensed health facility. However, if the home setting is not medically appropriate or available, the place of residence may

include congregate living situations or facilities licensed as congregate living health facilities (CLHF) in accordance with the California Health and Safety Code sections 1250(i), 1267.12, and 1267.13, 1267.16, 1267.17, and 1267.19, or a specialized foster care home, pursuant to W&I Code, Section 1773.1.

e.____ not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

   a._X_ Yes b.____ No

7. A waiver of Section 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

   a._X_ Yes, only as explained in Appendix C.

   b.____ No

   c.____ n/a

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

   a._X_ Yes b.____ No

   The beneficiary and, if appropriate, a beneficiary's representative will participate in the selection of available waiver services authorized in the Plan of Treatment (POT) utilizing the Menu of Home and Community-Based Services (MOHS) Waiver Service Form (Attachment D-6). Selection shall include consideration of the services' current identified costs up to the amount described in Appendix G, as may be amended from time to time.

9. A waiver of the "statewideness" requirements set forth in Section 1902(a)(1) of the Act is requested.

   a.____ Yes b._X_ No

   If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (specify):

10. A waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B-1 of this request, be included under this waiver:

a. X Case management

b. ____ Homemaker

c. X Home health aide services, to include shared Certified Home Health Aide services.

d. ____ Personal care services

e. X Respite care

f. ____ Adult day health

g. ____ Habilitation

_____ Residential habilitation

_____ Day habilitation

_____ Prevocational services

_____ Supported employment services

_____ Educational services

h. X Environmental accessibility adaptations

i. _____ Skilled nursing

j. _____ Transportation

k. ____ Specialized medical equipment and supplies

l. _____ Chore services

m. X Personal Emergency Response Systems

n. ____ Companion services

o. X Private duty nursing to include shared nursing services

p. X Family training

q. ____ Attendant care

r. ____ Adult Residential Care

_____ Adult Foster Care

_____ Assisted living

s.____ Extended State plan services (Check all that apply):

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

_____ Prescribed drugs

_____ Other (specify):

t._X__ Other services (specify):

__X__ Transitional Case Management (TCM) Services

__X__ Utility Coverage

__X__ Waiver Service Coordination

u.____ The following services will be provided to individuals with chronic mental illness:

_____ Day treatment/Partial hospitalization

_____ Psychosocial rehabilitation

_____ Clinic services (whether or not furnished in a facility)

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of treatment will be developed by qualified individuals as outlined in Appendix E of this application, for each individual under this waiver. The written plan of treatment is to be developed prior to the delivery of the requested waiver services. MCOD-IHO will assist the HCBS waiver service provider in the development of the plan of treatment as requested. All HCBS waiver service providers will be required to utilize the plan of treatment form developed by MCOD-IHO, which can also be found in the Attachments of Appendix E-2 of this application. This plan of treatment will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of treatment. The plan of treatment will be subject to the approval of the Medicaid agency. Federal Financial Participation (FFP) will not be claimed for waiver services furnished prior to the development of the plan of treatment. FFP will not be claimed for waiver services that are not included in the individual written plan of treatment.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, ICF/MR or Subacute centers, with the exception of TCM services to facilitate the transition from a facility to a home setting (refer to item 13).

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

    a. X When provided as part of respite care in a facility approved by the State that is not a private residence.

    b. ____ Meals furnished as part of a program of adult day health services.

    c. ____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

    For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to the Centers for Medicare and Medicaid Services (CMS).

    a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

        1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

        2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

        3. Assurance that all facilities covered by Section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

    b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The evaluations will be conducted by home visits made by MCOD-IHO nursing staff to the

waiver beneficiary at a minimum of once each year. The requirements and the details for the home visits for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to likely require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

a. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

b. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

c. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

d. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid funded institutional care that they require, as indicated in item 2 of this request.

e. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

f. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. _____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

    a.____ Yes b.__X__ No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2005 is requested.

20. The State contact person for this request is Patricia Lof, Chief of the Home and Community-Based Services Waiver Unit, Medi-Cal Rate Development Branch, who can be reached by telephone at (916) 552-9634

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under Section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: Stan Rosenstein

Title: Deputy Director

Medical Care Services

Department of Health Services

Date: _____

APPENDIX A, ADMINISTRATION

Line of Authority for Waiver Operation

CHECK ONE:

__X__ The waiver will be operated directly by the Medi-Cal Operations Division (MCOD), In-Home Operations (IHO) of the Department of Health Services (DHS), the Medicaid agency.

_____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

_____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for Appendix A, Monitoring and Oversight Plan

Monitoring And Oversight Plan

In-Home Operation

Home and Community-Based Services Waiver Monitoring Standards

1. It is the primary objective of the In-Home Medical Care (IHMC) Waiver to provide home and community-based waiver services (HCBS) to Medi-Cal beneficiaries who would otherwise reside in an institutional setting due to the severity of their chronic medical care needs. As a basis for providing services in the home setting, the home must be determined safe for the delivery of waiver-based services.

2. Medi-Cal Operations Division (MCOD), Home and Community-Based Services (HCBS) Branch, In-Home Operations (IHO) oversees the implementation of the IHMC Waiver services in the home for Medi-Cal beneficiaries, and determines if the services provided are appropriate, medically necessary, safe and cost neutral.

3. MCOD-IHO is responsible for the authorization of requested HCBS services and has no regulatory oversight for providers. All HCBS waiver providers will be required to sign the "Medi-Cal In-Home Operations Home and Community-Based Services (HCBS) Waiver Provider Agreement". The original signed document will be maintained in the beneficiary's MCOD-IHO chart.

   The HCBS providers primarily utilized are currently enrolled Medi-Cal providers who meet applicable state and federal licensing or certification criteria. Licensing and/or certification is done by other entities within the Department of Health Services (DHS). As outlined in statute and regulation, the regulatory agencies conduct periodic assessment of the Medi-Cal provider. There are also providers who are licensed individuals but who are not traditional Medi-Cal providers. These providers are licensed nurses who are regulated based upon standards of practice and licensure status. MCOD-IHO has established relationships with the licensing entities and collaborates with them as needed in the event problems arise involving the delivery of services for which the provider is licensed or certified to render. This collaboration includes identifying key contacts within these departments to call for questions or concerns regarding the delivery of services, information for filing reports of inadequate care and having the reports sent to MCOD-IHO based upon filed complaints made by either MCOD-IHO and/or the beneficiary.

   MCOD-IHO has statewide responsibility for training providers in terms of the HCBS waiver services. This training includes defining HCBS services, the available services under the waivers, provider enrollment activities, accessing the services for authorization, documentation requirements for authorization of services, general billing, eligibility information, record maintenance and findings from internal quality assurance activities as they relate to the delivery of HCBS Waiver Services. The type of training to be provided is determined either by a direct request, a need that is identified by the IHO nurse case manager for new or existing providers, or from findings identified as a result of quality assurance activities. Training is primarily conducted by the MCOD-IHO Nurse Consultant staff but may also include program staff such as the nurse case managers, analysts, and eligibility

liaisons. Through internal quality assurance activities, MCOD-IHO will also assess for priority training issues i.e. those that impact the health and safety of the waiver beneficiary or the appropriate implementation of the waiver program. Based upon the findings, in service trainings will be developed and implemented which may be directed towards waiver service providers, beneficiaries and/or MCOD-IHO program staff.

4. As the individual case warrants and prior to rendering care, a waiver service provider must demonstrate that they either meet applicable state or federal license requirements associated with the provision of the identified services, or that they have been properly trained by appropriate individual(s) to administer such care.

5. Upon a determination by MCOD IHO that all requirements have been met in terms of medical necessity for services and that the home is a safe environment for the delivery of the services, the following is completed:

   a. A "Freedom of Choice" document will be signed by the beneficiary or his/her authorized representative indicating that they were informed of the alternatives available to them and that it is their choice to either accept or decline HCBS waiver services. The original signed document will be maintained in the beneficiary's MCOD-IHO chart.

   b. A "Menu of Home and Community-Based Services Waiver Service"(MOHS) document is completed with participation by the beneficiary and/or their legal representative, the MCOD-IHO nurse case manager, the primary physician, the provider(s) of service(s) or any member of the beneficiaries identified circle of support. The MOHS is used to identify the services that are available and their current assigned costs for waiver purposes. This collaboration enables the beneficiary to directly participate in the selection of the services that meet the identified and authorized needs of the beneficiary while helping to ensure overall cost neutrality of the waiver program.

   c. An "Informing Notice" is sent to the primary physician, the beneficiary, an authorized representative or any member of the beneficiaries identified circle of support, and the provider of service indicating the roles and responsibility of each participant to ensure a successful, safe home program for waiver services. This notice also outlines the roles and responsibilities of the Department in the management of the waiver services. A copy of all of these letters will be maintained in the beneficiary's MCOD-IHO chart.

6. The following monitoring standards are employed by MCOD-IHO for:

   Initial Evaluations

   a. All new individuals applying for IHMC Waiver services are evaluated by the MCOD-IHO Intake Unit, which is comprised of Registered Nurses (RN). The Intake RN will access the assistance of a licensed Social Worker to assess for non-physical care services and needs for individual that are identified by IHO Intake RN, the individual, and/or members of the individual's circle of support. The Social Worker will work with the individual's case manager in the development of the POT to include non-physical care services and needs, providers and expected outcomes. The Intake Unit is responsible for the review of documentation that supports the need for the waiver. Documentation may

be submitted by the individual, primary care physician, other health care entities and/or legal representative.

- Evaluations conform to regulatory and statutory requirements and guidelines for Medi-Cal and waiver services.

  a. Verification that the home safety evaluation has been completed by either the provider of services or MCOD-IHO.

  b. The provider, with input from the beneficiary and, if appropriate, the authorized representative and the MCOD-IHO nurse case manager develop an individualized plan of treatment (POT), that is signed by the beneficiary or the authorized representative, the provider of service and the physician. The POT outlines the authorized waiver services to be provided in the home. Based on the MOHS, the provider incorporates into this plan the beneficiary's choice regarding overall delivery of waiver and related services, all in accordance with State and federal regulations.

  c. As warranted, the MCOD-IHO Intake Unit nurse will also make home visits to verify submitted information regarding the medical necessity of requested services and the safety of the home environment before the approval of case.

  d. In reviewing submitted documentation, any issues identified by the MCOD-IHO Intake nurse that may impact the appropriate and safe delivery of care are thoroughly evaluated. Issues may include such things as Medi-Cal eligibility, other insurance payer sources, Medi-Cal Managed Care enrollment, provider related issues, beneficiary and/or family related social issues, an inappropriately developed POT or MOHS, or a concern for home safety. The MCOD-IHO nurse works collaboratively with the beneficiary and/or the authorized representative, any members of the beneficiaries identified circle of support, the provider(s) of service(s) and the physician to accurately identify and resolve such issues. Once either the issues have been resolved, or a plan is in place for resolution, the case is approved.

  e. All relevant information collected in the development of the home program for waiver services is documented on the IMS report and is maintained in the beneficiaries MCOD-IHO record. Additional information may also be found in the running record in the MCOD-IHO record.

  f. Upon final approval, the case is assigned to an MCOD/IHO nurse case manager, who is a registered nurse for ongoing case management.

<u>Ongoing Case Management</u>

a. Ongoing case management is provided to ensure that the home program set up for the delivery of waiver services remains appropriate and medically necessary, that the home remains a safe environment for the beneficiary.

b. Case Management includes overall management and follow-up on issues identified during the initial intake process and any new issues that arise subsequent to the approval

of services. Activities include: routine home visits to the beneficiary at prescribed intervals described in the waiver; annual review of service(s); telephone contact with the physician as warranted; review of POT(s) and MOHS during on-site visits, upon any change in medical condition, or as additional services are requested; review and authorization of waiver and State Plan services according to state regulations; and, working with related persons and entities involved with the beneficiary's care.

c. The waiver must be administered in accordance with federal regulations, which specify that the waiver program must be "cost neutral." The waiver program is cost neutral if the average per capita annual Medicaid expenditure under the waiver does not exceed the average per capita annual Medicaid expenditure absent the waiver. Monitoring of individual beneficiaries on a regular basis is necessary to help ensure continued and consistent waiver viability and cost neutrality.

d. As issues are identified, the MCOD-IHO nurse case manager follows-up with the HCBS provider(s) of service(s), the physician, the beneficiary and, if appropriate, the authorized representative, for resolution.

e. All plans developed to resolve identified problems are thoroughly evaluated by the MCOD-IHO nurse case manager to ensure that they are appropriate, will result in a resolution which is amenable to all, and will continue to meet the needs of the beneficiary.

f. All contact made by the MCOD-IHO nurse case manager with a HCBS provider of service, the physician, or the beneficiary, related to identified problems are clearly summarized and documented in the MCOD-IHO chart, by the MCOD-IHO nurse case manager.

g. In the event a significant incident occurs jeopardizing the health safety and welfare of the beneficiary while under the care of a provider, the waiver provider shall submit written documentation to the MCOD-IHO nurse case manager for review A significant incident includes, but is not limited to, a complaint by the beneficiary regarding their waiver service provider and the care they are receiving; failure to provide services or supplies as ordered by the physician and described on the POT, or the neglect or abuse of the beneficiary. Any documentation regarding the incident will be filed in the beneficiaries MCOD IHO case file.

During scheduled or unscheduled home visits or provider visits any previously identified issue or incident will be followed-up in an appropriate manner. Identified issues include incidents that can potentially adversely impact a waiver beneficiary's health and safety, regardless of whether the incident resulted in harm. Identified issues will be monitored and tracked accordingly through internal quality assurance activities. The goal is to track and follow-up on issues that may directly or indirectly affect health and safety of the individual while under the waiver program. Direct incidents pertain to the actual care received, which may impact the physical or psychological health and safety of the individual. Indirect incidents pertain to aspects of the individuals living environment that may indirectly impact the health and welfare of the individual such as lack of needed

medical supplies or equipment or staff misconduct on behalf of the HCBS waiver service provider. Based upon the findings from these incidents will determine the appropriate action to be taken by MCOD-IHO and the subsequent follow-up. All incidents, direct or indirect, identified during the onsite visit are documented using the Event/Issue Report form. The MCOD-IHO nurse case manager will document the corrective measures taken in response to the incident, and monitor its implementation and outcome.

h. The specific nature of an issue or incident will determine if notification of others is warranted. If a determination is made that other persons or entities should to be notified, the provider of service will be given direction by the MCOD-IHO nurse case manager as to whom to contact and what documentation is required to be provided to MCOD-IHO.

i. On-site visits made to the home of the beneficiary are documented on the CMR form and are maintained in the MCOD-IHO chart. Home visit evaluations include assessing the continued medical necessity for services, home safety, identification of problems with plans for correction and follow-up, identification of social services that may be available in the community, the review of home medical record which contains the nursing notes, POTs, and the MOHS and the review of the cost neutrality of the program.

j. Cost Neutrality will be evaluated by tracking the costs of authorized waiver and state plan services received by the beneficiary. HCBS waiver services and state plan services authorized by MCOD/IHO will be tracked on the MOHS. The total of the two types of costs must be less than the identified institutional alternative for the beneficiary. If requested services are not cost neutral, they will not be authorized.

k. Annual on-site visits made to a provider of service will be documented on a "HCBS Provider Visit" report. The report will include appropriate information on staffing issues, necessary POT revisions, necessary MOHS revisions, review of case management notes made by the provider and any issue(s) identified by the provider related to the home program for the beneficiary.

Personal Care Services

The Department of Social Services (DSS) operates and administers the Medi-Cal State Plan Personal Care Services Program (PCSP) through an interagency agreement with the Department.

Department of Social Services

The In-Home Supportive Services (IHSS) or PCSP provider is hired by the Medi-Cal individual and is the employee of that individual. Any training needed is the responsibility of the individual. No formal training exists or is required by DSS for IHSS or PCSP providers. However, depending on the county in which an individual resides, their provider may receive training as a component of the Supported Individual Provider services (23 counties) or under a Public Authority (seven counties). A Public Authority is required, by statute, to provide training to its provider population. Providers may also receive training if they are employed by a contract agency that serves IHSS or PCSP beneficiaries.

Monitoring of the IHSS and PCSP regulatory requirements is provided through DSS' Adult Programs Branch, Evaluation and Integrity Bureau. Counties are evaluated approximately every four years.

Individual county departments of social services are responsible for both the initial and annual assessments of the IHSS and PCSP beneficiaries, and for the monitoring of authorized hours to ensure that the services are being provided (up to a maximum approved 283 hours per month). County departments of social services are not responsible for monitoring of any Personal Care Services authorized under the Medicaid waiver programs. The roles and responsibilities of monitoring the care provided by PCSP are outlined in the Interagency Agreement.

The DSS Manual for Social Services Standards, Chapter 30-700 Service Program NO 7: In-Home Supportive Services describe the policies and procedures for the needs assessment standards and service authorization.

Department of Health Services – Medi-Cal Operations Division

MCOD-IHO will work with DSS in coordinating the State Plan Personal Care Services (PCS) and the services available through this waiver. Individual under this waiver shall receive periodic case management visits from an identified waiver service case management provider. MCOD-IHO will work with the beneficiary, identified members of the beneficiary's circle of support, and/or waiver service case manager in obtaining identified training needs of the PCSP. If the there is an apparent change in the individual's need for PCS, the waiver case manager or MCOD-IHO will contact the county IHSS PCSP and request a needs assessment."

Establishment and Maintenance of a Waiting List

Each enrollment authorized under a waiver year within the In-Home Medical Care (IHMC) Waiver is referred to as a "waiver slot" for purposes of establishing and maintaining a waiting list for enrollment into the IHMC Waiver. Enrollment into the IHMC Waiver is limited to the maximum number of waiver slots authorized for each waiver year. When there are no available waiver slots for the current waiver year, the Department, through MCOD-IHO, will establish and maintain a waiting list of individuals eligible for potential enrollment in the IHMC Waiver. Waiver slots that become available due to the death of a beneficiary will be filled with a new beneficiary from the appropriate waiting list.

An individual requesting IHMC Waiver services must complete and return the HCBS Waiver Questionnaire to MCOD-IHO in order to be placed on the IHMC Waiver waiting list. MCOD-IHO will send a letter confirming receipt of the completed HCBS Questionnaire indicating the effective date of placement on the IHMC Waiver waiting list.

Available waiver slots will be assigned to IHMC Waiver eligible individuals who are on the waiting list in the following order:

1. Beneficiaries residing in a medical facility at the time of submission of the HCBS Questionnaire to MCOD-IHO.
2. Individuals residing in the community at the time of submission of the HCBS Questionnaire.

Multiple completed HCBS Questionnaires received on the same day shall be prioritized numerically based upon the applicant's birth date, 1 through 31, without consideration to the month or year. It is the responsibility of the individual on the IHMC Waiver waiting list to notify MCOD-IHO in writing of any change in circumstances that may change the individual's priority enrollment or wait list priority.

Open enrollment slots are filled on a rotating basis, offering the first opportunity for waiver enrollment to an individual at the top of the list of individuals residing in a medical facility wishing to transition to the community. The second opportunity for enrollment will be offered to the individual at the top of the list of who reside in the community. The third opportunity will be offered to the individual at the top of the list of individuals residing in a medical facility, and so forth. Once offered the opportunity to enroll in the IHMC Waiver the individual must begin the intake/enrollment process within **60** days of notification. If the individual is unable or declines waiver enrollment the open waiver slot will be offered to the individual at the top rank in the order of rotation.

Priority enrollment into the IHMC Waiver is given to individuals who meet all the following criteria:

1. Must be a current Medi-Cal beneficiary who will turn 21 years of age during the current waiver year;
2. The beneficiary must be receiving private duty nursing services under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) at the IHMC level of care in the month prior to enrollment in the IHMC Waiver;
3. The beneficiary must submit a completed HCBS Waiver Questionnaire; and
4. The beneficiary is eligible for placement into the IHMC Waiver.

MCOD-IHO may hold waiver slots for priority enrollment beneficiaries to prevent interruption of home and community based services.

An individual who is notified of an available waiver slot on the IHMC Waiver must begin the intake/enrollment process within 60 days of notification. An individual who has not advised MCOD-IHO of their intention to elect to receive waiver services within 60 days or who declines waiver services shall not be enrolled in the waiver and that individual shall be sent a Notice of Action terminating the availability of waiver services. Individuals who do not respond or fail to begin the intake/enrollment process within 60 days of notification of waiver slot availability or who decline waiver services shall also be removed from the IHMC Waiver waiting list and sent a Notice of Action.

To assist in the transition to home and community based services, individuals who are residing in a medical facility who are offered waiver slots are encouraged to enroll into the IHMC Waiver as soon as possible so that those individuals may receive Transitional Case Management (TCM) services, as described in the waiver, prior to discharge to coordinate services such as housing, equipment, supplies or transportation that may be necessary to leave a health care facility. TCM services may begin up to 180 days prior to discharge from an institution.

Appendix A, Attachments

Attachment #1, Notification Letter "Beneficiary Without Service Provider"

Attachment #2, Notification Letter "Beneficiary Refuses Waiver Services, Name Removed From List"

Attachment #3, Notification Letter "Any New Referral"

Attachment #4, "Home and Community-Based Services (HCBS) Waiver Questionnaire"

Attachment #1, Notification Letter "Beneficiary Without Service Provider"

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date

TO: BENEFICIARY NAME
BENEFICIARY ADDRESS

Dear «Salutation»:

Medi-Cal In-Home Operations (IHO) is ready to process your request for services for the Home- and Community-Based Services (HCBS) In-Home Medical Care (IHMC) Waiver. According to our records, you do not have an identified HCBS Waiver service provider.

We conducted our evaluation of your request on «Date_of_Contact». We have yet to receive follow-up information from you. Please be advised that you have thirty (30) days to respond before IHO closes this case due to lack of activity. If this case is closed, «Bene_Name» will lose Medi-Cal eligibility.

If a service provider is not identified by «Closure_Date», your case will be closed. You may reapply for waiver services in the future by submitting a new request and questionnaire.

If you have any questions, please contact Ms. «NE_II_Name», R.N., Nurse Evaluator II, at (916) «NE_II_Number».

Sincerely,

Nurse Evaluator III, Supervisor
In-Home Operations, Intake Unit

cc: «NE_II_Name», R.N.
Nurse Evaluator II
In-Home Operations

(BENEFICIARY WITHOUT SERVICE PROVIDER)

1501 Capitol Avenue, MS 4502; P.O. Box 997419; Sacramento, CA 95899-7419
(916) «NE_II_Number»
Internet Address: www.dhs.ca.gov

Attachment #2, Notification Letter "Beneficiary Refuses Waiver Services, Name Removed From List"

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

<DATE>

TO: BENEFICIARY NAME
BENEFICIARY ADDRESS

Medi-Cal In-Home Operations (IHO) has received a request on your behalf for Home and Community-Based Services (HCBS) under the In-Home Medical Care (IHMC) Waiver. Per the call made to your home on <DATE>, you indicated you were no longer interested in pursuing services under the IHMC Waiver. If you have reconsidered this decision, please contact the IHO Intake Unit at (916) 552-9105. Enclosed with this letter is the "Freedom of Choice" document, which indicates your choice to "Accept" or "Decline" Home and Community-Based Services waiver services.

The "Freedom of Choice" document requires your signature. Please sign and date as indicated and **return within five days** of receipt of this letter in the enclosed self-addressed envelope. Postage ***is not*** included, so please make sure you affix the proper postage amount. This document will be kept in your files at the designated IHO office. It is suggested that you make a copy for yourself prior to mailing this document back to IHO.

If IHO has had no response from you by <DATE (2wk standard time)> your name will be removed from the waiting list and the program will proceed with contacting other individuals on the waiting list. Please know you are welcome to contact the Intake Unit at (916) 552-9105 with any questions.

Sincerely,

<Name, Title>

(BENEFICIARY REFUSES WAIVER SERVICES, NAME REMOVED FROM LIST)

1501 Capitol Avenue, MS 4502; P.O. Box 997419; Sacramento, CA 95899-7419
(916) «NE_II_Number»
Internet Address: www.dhs.ca.gov

Attachment #3, Notification Letter "Any New Referral"

State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

<DATE>

TO: BENEFICIARY NAME
BENEFICIARY ADDRESS

The Medi-Cal In-Home Operations (IHO) Section has received a request on your behalf for one of the Home- and Community-Based Services (HCBS) Waivers we administer. The IHO HCBS Waivers include the Nursing Facility Level A or Level B (NF A/B) Waiver, NF Subacute Waiver for adult or pediatric level of care, and In-Home Medical Care Waiver for hospital level of care. Please be advised that all waivers have a limit as to the number of people that can receive services.

Referrals for HCBS Waiver services are evaluated on a first-come, first-served basis. At the time your referral is being reviewed, IHO will contact you to determine your continued interest in being considered for these services. As a reminder, you may have access to other Medi-Cal State Plan services through the appropriate Medi-Cal Field Office.

Enclosed with this letter is a Home- and Community-Based Options Brochure from IHO and an HCBS Waiver questionnaire for medical care needs. This questionnaire must be completed and returned to our office. Upon the return of the questionnaire to IHO, it will be date stamped and a preliminary review will be made to determine if you meet the level-of-care requirements for one of the HCBS Waivers. If the preliminary findings suggest that you will be eligible for an IHO HCBS Waiver that has reached the maximum number of individuals it can serve, your name will be added to the appropriate HCBS Waiver waiting list, based upon the date IHO received the questionnaire. If there are any questions/concerns regarding the information provided, you will be contacted by IHO to discuss the area(s) of concern. If there are no concerns with the information provided, your name will be added to the list and you will be contacted as indicated above.

If you should move, have a significant change in your health care needs, have a change in your Medi-Cal eligibility status, or have any questions regarding this letter, please feel free to contact IHO, at (916) 552-9105.

Sincerely,

<Name, Title>

(ANY NEW REFERRAL)

1501 Capitol Avenue, MS 4502; P.O. Box 997419; Sacramento, CA 95899-7419
(916) «NE_II_Number»
Internet Address: www.dhs.ca.gov

Attachment #4, "Home and Community-Based Services (HCBS) Waiver Questionnaire"

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Home- and Community-Based Services (HCBS) Waiver Questionnaire

⇒ *Para recibir esta información en español, por favor llámenos a uno de los números siguientes: (916) 552-9292.*

To apply for one of the Medi-Cal HCBS Waivers administered by the In-Home Operations (IHO) Section, please complete this two-page form and return it by mail to IHO. **Your application will be processed upon IHO's receipt of this completed document**. If you need help filling out this form, please call IHO at (916) 552-9105.

Beneficiary's Name: _____ SSN: _____-____-_____

Mailing Address:_____ City: _____, CA, ZIP: _____

Street Address:_____ City: _____, CA, ZIP: _____

Beneficiary's Date of Birth: _____ Home Phone: (____)_____ Married: ☐ Yes ☐ No

Medical Insurance: ☐ Medi-Cal ☐ Medicare ☐ Other _____

_____ _____ (____)_____

Person completing this form if other than the beneficiary | Relationship to the beneficiary | Home or Business Phone

List current medical diagnoses (main illness or injury) below:

Primary _____

Secondary _____

Additional _____

Check the boxes that identify your current medical needs. Use the blank spaces below to write-in your specific medical needs that are not listed.

☐ Ventilator - Hours Used Per Day (hrs/day) _____
☐ Continuous Positive Airway Pressure (CPAP) Device – hrs/day ____
☐ Bi-Level Positive Airway Pressure (BiPAP) Device – hrs/day _____
☐ Respiratory Treatments - number per day _____
☐ Pulse Oximetry ☐ Continuous Oxygen

☐ Tracheostomy
☐ Tracheal Suctioning
☐ Oral Suctioning
☐ Nasal Suctioning
☐ Oxygen as needed

☐ Oral (by mouth) Medications
☐ Gastric Tube (GT) Medications
☐ Intravenous (IV) Medications
☐ Chronic Pain Treatment
☐ Contractures

☐ Oral (by mouth) Feedings
☐ Gastric Tube (GT) Feedings
☐ Intravenous (IV) Nutrition
☐ Pressure Sores/Open Wounds
☐ Skin or Wound Treatments

☐ Urinary Incontinence
☐ Bladder Catheterizations
☐ Bowel Incontinence
☐ Routine Bowel Care
☐ Urostomy/Colostomy

☐ Some ability to move arms or legs. Needs some help with care needs. Briefly explain on back.
☐ No movement of arms or legs. Needs total help with care needs. Briefly explain on back.
☐ Special equipment needs. (ex: wheelchair, lift system, ramp) Briefly explain on back
☐ Other_____ ☐ _____ ☐ _____

(Write additional comments on back.)

1501 Capitol Avenue, MS 4502; P.O. Box 997419; Sacramento, CA 95899-7419
(916) «NE_II_Number»
Internet Address: www.dhs.ca.gov

HCBS Waiver Questionnaire *continued*

Please identify all of your current providers of service:

☐ Home health Agency (HHA: _____Hours per week: _____

☐ Attendant Care ☐ CHHA (Aide) ☐ Licensed Vocational Care (L.V.N.) ☐ Registered Nurse (R.N.)

☐ In-Home Supportive Services (IHSS) Hours Authorized Per Month: _____
Call your local county Department of Social Services office and ask for the IHSS Intake Department for eligibility information.

☐ California Children's Services (CCS) - Please check the CCS services received:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Medical Social Worker

☐ Regional Center – Name: _____ Respite Hours Authorized Per Quarter: _____

☐ Adult or Pediatric Day Health Care – Name: _____ Days per week: _____

Do you attend school outside of the home? ☐ Yes ☐ No

If yes, how many days/week do you attend school? _____ How many hours/day? _____

Does the school provide medical assistance for you? (Ex.: attendant worker) ☐ Yes ☐ No

Please list other agencies or health programs you have contacted to request assistance with home care: (Ex.: Intermittent Home Health Agency services, Outpatient Services, etc.)

☐ Multi-Service Senior Program (MSSP)

- *MSSP is an HCBS waiver benefit for Medi-Cal beneficiaries over the age of 65 that provides general services and nursing support throughout the state.*

☐ Hospice

- *Hospice is a Medicare/Medi-Cal benefit for clients with a terminal diagnosis.*

☐ Medical Case Management (MCM)

- *MCM offers short-term medical care services for beneficiaries without other sources of health insurance.*

Please list other agencies or health programs you have contacted to request assistance with home care: (e.g.: Intermittent Home Health Agency Services, Outpatient Services, etc.)

_____ _____

_____ _____

Additional Information/Comments:

_____

_____

When you are finished, please return this form to IHO in the self-addressed envelope we have provided you. Should you relocate, have a significant change in your health care needs, or change your Medi-Cal insurance status, please contact IHO at (916) 552-9129 or (916) 552-9134.

Enclosure

APPENDIX B, SERVICES AND STANDARDS

Appendix B-1, Definition Of Services

At no time shall IHO authorize direct care services or any combination of direct care services under the waiver to exceed 24 hours per day. Direct care services may include State Plan services, i.e., In-Home Supportive Services, adult or pediatric day health care and/or direct care authorized by the beneficiary's private insurance. Direct care is defined as hands on care to support the care needs of the beneficiary.

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. X Case Management

X Services that will assist individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. These services are provided in cooperation with Medi-Cal Operations Division, In-Home Operations (MCOD-IHO).

Because the primary needs of the In-Home Medical Care (IHMC) waiver recipients are medical in nature, it is generally preferable in terms of managing the overall health and safety of the beneficiary to have the case management function performed by a person with a medical based background. However, there may be occasions where the beneficiary chooses to have their case manager be a person who is a Marriage and Family Therapist (MFT), Licensed Psychologist or Licensed Clinical Social Worker (LCSW), or an entity who employs such persons. Therefore, if appropriate, the following persons may provide case management services:

1. A Registered Nurse (RN) employed by a home health agency (HHA);
2. A RN, also known as an Home and Community-Based Services Waiver RN (HCBS Waiver RN), under the direction of a licensed physician;
3. A HCBS Benefit Provider; an individual licensed and certified by the State of California such as MFT, Licensed Psychologist, or LCSW; or
4. A Professional Corporation; an entity or organization that is licensed and certified by the State of California to provide the services of a MFT, Licensed Psychologist, or LCSW.

Case managers, described above, shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of treatment and Menu of Home and Community-Based Services Waiver Service (MOHS) Form.

1. X Yes 2. _____ No

The waiver service providers for case management will have responsibility for the ongoing, routine aspects of waiver services being provided in the home. Waiver service providers will have the direct contact with the beneficiary and, as applicable, the assigned nursing staff, and the physician. Waiver service providers will oversee the implementation and evaluation of all services identified in the POT and offered in the MOHS. Case management responsibilities include assessing, care planning, authorizing, locating, coordinating and monitoring a package of long-term care services for community-based clients. These services may be provided by an entity or organization of trained professionals or by a State licensed individual provider.

Case managers employed by MCOD-IHO shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care and MOHS at such intervals as are specified in Appendices D & E of this request.

1. X Yes 2. ____ No

The "case management" to be provided by MCOD-IHO staff is primarily administrative in nature and will consist of such things as monitoring to help ensure the services provided by the waiver service provider are in accord with State and federal guidelines. The initial and ongoing assessment of level of care, review of the POT, and review of the MOHS are included in the monitoring activities.

MCOD-IHO case managers will provide for utilization review of authorized State Plan and waiver services as outlined in Title 22, California Code of Regulations (CCR), section 51003. MCOD-IHO case managers will also be responsible for routine follow-ups with the waiver service case manager to:

1. Determine whether the authorized waiver services are appropriate and meet the identified needs of the beneficiary;
2. Ensure level of care determinations are accurate;
3. Identify, resolve, or ensure a plan is in place for resolution of issues affecting the beneficiary;
4. Review and authorize requests for waiver services and appropriateness of State Plan services as indicated in the POT/MOHS; and
5. Review the cost neutrality of the program.

MCOD-IHO case management will be accomplished through the use of regular telephone contact with the waiver service case manager, home visits to the beneficiary, and yearly, or more frequent as appropriate, provider case conferences.

_____ Other Service Definition (Specify):

b.____ Homemaker:

_____ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

c._X_ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration, and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State Plan.

_X_ Other Service Definition (Specify):

Home health aide services under this waiver will be provided on a shift basis for patients who require individual and continuous care. These services shall meet the following requirements:

1. Is provided by a certified home health aide employed by a licensed and certified home health agency under medical orders prescribed by a physician or other licensed practitioner within his or her scope of practice;
2. Is provided to the patient in his or her temporary or permanent place of residence or other community-based setting and includes one or both of the following locations: (a) the patient's home, (b) Outside of the patient's home, as necessitated by normal life activities.

"Shared Home Health Aide Services" under the waiver are services provided by one certified home health aide to two NF Level A and B, NF Subacute, or IHMC Waiver beneficiaries residing in the same home in accordance with the attending physician's orders, the written Plan of Treatment and the MOHS. Shared home health aide services will only be provided upon request by the beneficiary or his/her authorized representative

d.____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of treatment, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are

essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

   _____ Payment will not be made for personal care services furnished by a member of the individual's family.

   _____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

   Justification attached. (Check one):

   _____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

   _____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

   _____ A registered nurse, licensed to practice nursing in the State.

   _____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

   _____ Case managers

   _____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

   _____ As indicated in the plan of treatment

   _____ Other (Specify):

4. Relationship to State plan services (Check one):

   _____ Personal care services are not provided under the approved State plan.

   _____ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. X Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

X Other service definition (Specify): Intermittent or regularly scheduled temporary medical care and supervision provided in the beneficiary's own home or in an approved out-of-home location to do all of the following:

1. Assist family members in maintaining the beneficiary at home;
2. Provide appropriate care and supervision to protect the beneficiary's safety in the absence of family members;
3. Relieve family members from the constantly demanding responsibility of caring for a beneficiary; and
4. Attend to the consumer's medical needs and other activities of daily living, which would ordinarily be performed by the service provider or family member.

Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

X Individual's home or place of residence

_____ Foster home

X Medicaid certified Hospital

_____ Medicaid certified Nursing Facility, or

_____ Medicaid certified ICF/MR

_____ Group home

_____ Licensed respite care facility

X Other community care residential facility approved by the State that is not a private residence (Specify type): HCBS Nursing Facility (Congregate Living Health Facility (CLHF))

_____ Other service definition (Specify):

f.____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of treatment will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

(Check one):

1._____ Yes 2._____ No

_____ Other service definition (Specify): Qualifications of the providers of adult day health services are contained in Appendix B-2.

g.____ Habilitation:

_____ Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation that shows Medicaid payment does not cover these components is attached to Appendix G.

_____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-

residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of treatment.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of treatment. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

_____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF, or ICF/MR.

Check one:

_____ Individuals will not be compensated for prevocational services.

_____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of treatment as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available

under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, NF, or ICF/MR at some prior period.

_____ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

_____ Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.____ Yes 2.____ No

_____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations:

X Those physical adaptations to the home, required by the individual's plan of treatment and selected in the MOHS, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

All environmental modification services are subject to prior authorization by the MCOD-IHO nurse case manager. Requests for prior authorization for any and all modifications to a residence, which is not the property of the waiver recipient, shall be accompanied by written consent from the property owner for the requested modifications. Environmental modification services are payable to a total maximum amount of $5,000.

The only exceptions to the $5,000 total maximum are if:

1. The recipient's place of residence changes; or
2. In the opinion of the MCOD-IHO nurse case manager, and based upon review of appropriate documentation, the waiver beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and without which, the recipient would require institutionalization.

Absent written authorization from the owner, environmental accessibility modifications will not be authorized or be subject to compensation for residential care providers or rental units. To the extent possible, modifications will be made to the residence prior to occupation by the beneficiary. Upon commencement of

the modification, all parties will receive written documentation that the modifications are permanent, and that the State is not responsible for removal of any modification if the beneficiary ceases to reside at a residence, which is rental property.

All requests for environmental accessibility modifications submitted by a provider should include the following information:

1. Physician's order specifying the requested equipment or service;
2. Physical Therapy evaluation and report to assess the medical necessity of the requested equipment or service. This should typically come from an entity with no connection to the provider of the requested equipment or service. The Physical Therapy evaluation and report should contain at least the following information:
    a. An assessment of the beneficiary and the current equipment needs specific to the individual, describing how/why the current equipment does or does not meet the needs of the beneficiary.
    b. An assessment of the requested equipment or service and description how/why it is necessary for the beneficiary. This should include the ability of the beneficiary and/or the primary caregiver to learn about and appropriately use any requested item.
    c. Description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the beneficiary and a description of the inadequacy.
3. Medical Social Worker evaluation and report to assess for other community resources available to provide the requested equipment or service, the availability of the other resources, and any other pertinent recommendations related to the requested equipment or service. This should include the description of the availability of Other Health Care (OHC) coverage to provide for the requested equipment or service.
4. Depending on the type of adaptation or modification requested, documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the beneficiary, including any supporting documentation describing the efficacy of the equipment. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the beneficiary will still be necessary describing how and why the equipment or service meets the needs of the individual.
5. If possible, include a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties.
6. The MCOD-IHO nurse case manager will take the appropriate action on the TAR after all requested documentation has been received, reviewed, and a

home visit has been conducted by appropriate program staff to determine the suitability of any requested equipment or service.

Because of the maximum allowed cost of $5,000 for an adaptation, the use of this service will necessarily result in a reduction in the amount of other services the beneficiary may receive in the year the adaptation is authorized. Since the waiver must remain cost neutral, it is very important that the fiscal impact of this service be clearly understood by the beneficiary at the time of request for the accessibility adaptation and before the authorization of the modification service,

_____ Other service definition (Specify):

i.____ Skilled nursing:

_____ Services listed in the plan of treatment which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j.____ Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of treatment. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of treatment. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

_____ Other service definition (Specify):

k.____ Specialized Medical Equipment and Supplies:

_____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of treatment, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design, and installation.

_____ Other service definition (Specify):

l._____ Chore services:

_____ Services needed to maintain the home in a clean, sanitary, and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, property owner, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the property owner, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

m._X_ Personal Emergency Response Systems (PERS)

_X_ PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or are alone for significant parts of the day, or have no regular caregiver, or who would otherwise require supervision.

PERS is a 24-hour emergency assistance service that enables the beneficiary to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the beneficiary and includes training, installation, repair, maintenance, and response needs. The following types are allowed:

1. 24-hour answering/paging;
2. Beepers;
3. Med-alert bracelets;
4. Intercoms;
5. Life-lines;
6. Fire/safety devices, such as fire extinguishers and rope ladders
7. Monitoring services
8. Light fixture adaptations (blinking lights, etc.);
9. Telephone adaptive devices not available from the telephone company;
10. Other electronic devices/services designed for emergency assistance.

By providing immediate request for or access to assistance, PERS services prevent institutionalization of a waiver beneficiary. PERS services will only be provided as a waiver service to a beneficiary residing in a non-licensed environment.

All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. The cost effectiveness of this service is shown in Appendix G. Prior authorization for PERS services must be obtained by the DHS approved waiver service provider from the designated Medi-Cal office.

_____ Other service definition (Specify):

n.____ Companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of treatment, and is not purely diversional in nature.

_____ Other service definition (Specify):

o. X Private duty nursing (PDN):

X Individual and continuous care (in contrast to part time or intermittent care) provided by a licensed and certified home health agency (HHA), a Congregate Living Health Facility-Type (CLHF), a certified home health aide (CHHA) under a HHA, or a Home and Community-Based Services (HCBS) Waiver licensed nurses within the scope of State law. These services are provided to an individual at home.

The supervision and monitoring of PDN and Shared PDN services by a HCBS Licensed Vocational Nurse (LVN) is provided for by the HCBS Registered Nurse.

X Shared Private Duty Nursing Services

"Shared Private Duty Nursing Services" under the waiver are provided by a licensed RN, LVN, or CHHA under a HHA, an HCBS Waiver, Registered Nurse (RN) or HCBS Waiver, Licensed Vocational Nurse (LVN) or a CLHF in accordance with the attending physician's orders, the written plan of treatment and the MOHS. Shared nursing is the provision of nursing services for two beneficiaries who live in the same residence and share a nurse amongst

themselves, i.e., one nurse for two beneficiaries. This service will only be provided upon request by the beneficiary or his/her authorized representative.

Shared nursing services/certified home health aide services will be provided as private duty nursing services and defined in this Section, in units of one hour and will include a description of the practitioner's skill level (e.g., shared nursing – Registered Nurse; shared nursing – Licensed Vocational Nurse; shared home health aide services – Certified Home Health Aide).

_____ Other service definition (Specify):

p. X Family training:

X Training and counseling services for the families of individuals served on this waiver. For purposes of this service "family" is defined as:

1. The persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws, and;
2. May include other responsible persons who agree to act as an uncompensated caregiver in the absence of a waiver service provider.

"Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of treatment, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of treatment.

Family training services shall be rendered by a Registered Nurse. Pursuant to California statute governing RN's (Business and Professions Code, Division 2, Chapter 6, section 2727) gratuitous nursing by family members is not prohibited as long as these individuals are not in any way assuming practice as a professionally registered nurse. The physician and the provider of service will initially carry out family training jointly. If the beneficiary's physician, provider of services or the IHO Nurse case manager in consultation with the physician and provider of services determines that additional family training is required, it will be provided by the provider of service with appropriate documentation of the training rendered. The MCOD-IHO staff will review training and its appropriateness on a case-by-case basis and will include follow-up on training for all beneficiaries and their families during scheduled on-site visits to the home.

Under certain circumstances there may be times when the nursing care services provider is unable to provide the total number of authorized hours. In the event this occurs, the back-up system for care should be implemented. The identified individuals who will participate in this back-up system for the care needs of the beneficiary should have received the appropriate supportive training. Training of

family and provision of nursing care services by family members as warranted shall be identified on the physician-approved POT.

_____ Other Service Definition (Specify):

q.____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of treatment.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the beneficiary's individual plan of treatment.

_____ Other supervisory arrangements (Specify):

_____ Other Service definition (Specify):

r.____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed six. Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State

law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The beneficiary has a right to privacy. Living units may be locked at the discretion of the beneficiary, except when a physician or mental health professional has certified in writing that the beneficiary is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The beneficiary retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way that fosters the independence of each beneficiary to facilitate aging in place. Routines of care provision and service delivery must be beneficiary-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

_____ Home health care

_____ Physical therapy

_____ Occupational therapy

_____ Speech therapy

_____ Medication administration

_____ Intermittent skilled nursing services

_____ Transportation specified in the plan of treatment

_____ Periodic nursing evaluations

_____ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s.____ Extended State Plan services:

The following services, available through the approved State Plan, will be provided, except that the limitations on amount, duration, and scope specified in the plan will not apply. Services will be as defined and described in the approved State Plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State Plan until the plan limitations have been reached. Documentation of the extent of service(s) and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing, and language services

_____ Prescribed drugs

_____ Other State Plan services (Specify):

t.__X__ Other waiver services that are cost-effective and necessary to prevent institutionalization (Specify):

1.__X__ Utility Coverage: Electric services necessary to prevent reinstitutionalization for waiver beneficiaries at the IHMC level of service, who are dependent upon medical technology. Utility coverage must be included in the POT and the MOHS. Prior authorization must be obtained by the waiver service provider from the designated Medi-Cal office for this service.

There is a minimum monthly amount of $20.00 that must be reached before this service will be authorized. When the minimum amount has been reached, the

waiver will reimburse the beneficiary all charges up to a monthly maximum amount of $75.00.

Utility coverage is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the beneficiary's place of residence. For purposes of this waiver service, "life sustaining medical equipment" is defined as: mechanical ventilation equipment and other respiratory therapy equipment, suction machines, cardio-respiratory monitors, feeding pumps, and infusion equipment. Notwithstanding this definition, in the event, a specific medical need is identified in the POT, a consultation between the IHO Nurse Case Manager and the IHO program consultants (medical or nursing) will evaluate requests for and may grant exceptions to this definition.

Utility coverage is provided through the local utility company. The waiver service provider will submit a request for the authorization of this service. Upon receipt of payment for any claim for this service, the waiver service provider will then give the monies to the beneficiary.

In order to calculate the cost per unit of time, the authorization for waiver utility services includes consideration of the type of equipment and frequency of use. Cost factors to operate electrical equipment are supplied by utility companies and are based on a consideration of the equipment's size, voltage requirement, and amperage requirement. Upon identifying the power requirements of the equipment and the utility rates per kilowatt-hour, a MCOD-IHO can estimate the cost of operation of the equipment to within a few cents per unit of time.

The waiver service provider is responsible for assuring notification to utility providers that services are being provided to an individual dependent upon life sustaining medical equipment. Documentation indicating this notification has been made and, as appropriate, revised shall be kept in the beneficiary's medical record in the provider's files.

2. X Waiver Service Coordination: Coordination of needs for individuals who have complex medical services with multiple funding sources through public or private entities for needed services to be maintained in home or community based settings. These multiple funding sources could include Medi-Cal related services, California Children's Services for individuals under the age of 21, Regional Center, Department of Rehabilitation, county funded services, Medicare, private insurance.

This service will include educating the beneficiary and/or caregivers about the different funding sources and helping to assist the beneficiary and/or caregivers in understanding the various services he/she is receiving or may receive and the impact, if any, of the services received/requested, based on the source of funding. Waiver Service Coordination will supplement the case management activities authorized under this waiver or through other entities including the State Plan benefit of targeted case management. Waiver Service Coordination activities will

not involve the authorization of services, care planning or locating needed services. Waiver service coordination is not available under any other Medi-Cal (Medicaid) program including EPSDT.

The requested service with supporting documentation submitted to substantiate the medical necessity for the requested service, as well as credentials for providing these requested services, will be thoroughly reviewed by MCOD-IHO staff assigned to the case.

a. Services provided by family members: Waiver Service Coordination providers may be members of the individual's family. Payment will not be made for services furnished by the person legally responsible for the individual. This would include parental responsibilities for a minor or spouse of the individual. Legally responsible individuals may be used for this service in the event there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. MCOD-IHO may require additional documentation to support requests of this nature. Documentation required before MCOD-IHO can authorize such request, is a written explanation of the attempts made to enlist and retain a WSC provider, such as a posting classified advertisements, contacting Professional Corporations who employ individuals who qualify as WSC providers as described in Appendix B-4, a description of efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

b. Justification: Individuals who provide Waiver Service Coordination services must meet the standards as indicated in subsection a (page B-1).

- Criteria for service provider(s) will include written documentation of experience in coordinating such services and how they will coordinate the waiver services with other services received by the beneficiary. This documentation will be included on the POT and updated as needed. Must include service coordination beyond the use of Medi-Cal linked services and Regional Center services.

3. _X_ Transitional Case Management (TCM) Services: TCM services are provided to transition a Medi-Cal waiver eligible individual from a health care facility to a home and community-based setting. TCM providers will have direct contact with the beneficiary, their circle of support and the individual's primary physician to obtain information that will allow the TCM provider to coordinate services such as housing, equipment, supplies, or transportation that may be necessary to leave a health care facility. TCM services may be provided up to 180 days prior to discharge from an institution. All TCM services provided will be billed against the waiver on the date of waiver enrollment. If the beneficiary should decease before discharge, the TCM services provided may be claimed as an administrative expense under the State Plan.

This service will include an assessment of the individual's medical and non-medical care needs, circle of support, home setting and funding sources to support the individuals choice to transition from the facility to a home and community-based setting. In addition, the TCM provider will advocate for the individual in obtaining the services required to support the individual's transition to a home setting. These services will be provided prior to the individual's enrollment in the IHMC Waiver. The TCM provider will coordinate the transition of services with the individual's waiver case manager and waiver service coordinator, when appropriate, upon the individual's enrollment to the IHMC Waiver. TCM services are not available under any other Medi-Cal (Medicaid) program including EPSDT.

Requests for this service shall be accompanied by written POT that shall include the following: the medical and non-medical care needs, plan to access and expected outcomes.

Transitional Case Management services are provided by the following provider types:

1. A Registered Nurse (RN) employed by a home health agency (HHA);
2. A RN, also known as an HCBS Waiver RN, under the direction of a licensed physician;
3. A HCBS Benefit Provider; an individual licensed and certified by the State of California such as MFT, Licensed Psychologist, or LCSW; or
4. A Professional Corporation; an entity or organization that is licensed and certified by the State of California to provide the services of a MFT, Licensed Psychologist, or LCSW.

u.____ Services for individuals with chronic mental illness consisting of (Check one):

____ Day treatment or other partial hospitalization services (Check one):

____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

Appendix B-2, Provider Qualifications

Provider Qualifications

A. Licensing and Certification Chart

The following chart indicates the requirements for the provision of each service under the waiver. Licensing, Regulation, Statute, and California Code of Regulations are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider Type	Practitioner	License	Certification	Other Standard
Case Management	HCBS Benefit Provider	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §2902, §2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Case Management	HCBS Waiver Registered Nurse	RN	CCR Title 22, §51067 BPC §§2725-2742		Appendix B-4, Standards of Participation
Case Management	HHA	RN	CCR Title 22, §§74659–74689 CCR Title 22, §51067; BPC §§2725-2742		
Case Management	Professional Corporation	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §2902, §2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Environmental Accessibility Adaptations	DME provider, building contractor, private nonprofit or proprietary agency.		Contractor or Business License		Appropriate for the services purchased
Family Training	HCBS Waiver Registered Nurse	RN	CCR Title 22, §51067 BPC §§2725-2742		
Family Training	HHA	RN	HHA: CCR Title 22, §§74659–74689 RN: CCR Title 22, §51067; BPC §§2725-2742		
Home Health Aide Service, Individual or Shared Care	HHA	CHHA	HHA: CCR Title 22, §§74659–74689		
Personal Emergency Response Systems	DME provider, private nonprofit or proprietary agency.		Business license		Appropriate for the services purchased

Service	Provider Type	Practitioner	License	Certification	Other Standard
Private Duty Nursing, Individual or Shared Nursing Care	HCBS Waiver Licensed Vocational Nurse	LVN	LVN: CCR Title 22, §§51069 BPC §§2859-2873.7		Appendix B-4, Standards of Participation
Private Duty Nursing, Individual or Shared Nursing Care	HCBS Waiver Registered Nurse	RN	CCR Title 22, §51067 BPC §§2725-2742		Appendix B-4, Standards of Participation
Private Duty Nursing, Individual or Shared Nursing Care	HHA	RN, LVN	RN: CCR Title 22, §51067 BPC §§2725-2742 LVN: CCR Title 22, §51069 BPC §§2859-2873.7 HHA: CCR Title 22, §§74659–74689		
Private Duty Nursing, Individual or Shared Nursing Care	HCBS Nursing Facility	CLHF (RN, LVN, CNA)	CLHF: HSC 1250(i), 1267.12, 1267.13, 1267.16, 1267.17, and 1267.19 CCR Title 22, §51003, §51344		Appendix B-4, Standards of Participation
Private Duty Nursing, Individual or Shared Nursing Care, Supervision	HCBS Waiver Registered Nurse	RN	RN: CCR Title 22, §51067 BPC §§2725-2742		Appendix B-4, Standards of Participation
Respite	HCBS Waiver Licensed Vocational Nurse	LVN	LVN: CCR Title 22, §51069; BPC §§2859-2873.7		Appendix B-4, Standards of Participation
Respite	HCBS Waiver Registered Nurse	RN	CCR Title 22, §51067 BPC §§2725-2742		Appendix B-4, Standards of Participation
Respite	HHA	RN, LVN, CHHA	HHA: CCR Title 22, §§74659–74689 RN: CCR Title 22, §51067; BPC §§2725-2742 LVN: CCR Title 22, §51069; BPC §§2859-2873.7		
Respite	HCBS Nursing Facility	CLHF (RN, LVN)	CLHF: HSC 1250(i), 1267.12, 1267.13, 1267.16, 1267.17, and 1267.19 CCR Title 22, §51003, §51344		
Other Services:					
Transitional Case Management	HCBS Benefit Provider	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §§2902-2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Transitional Case Management	HCBS Waiver Registered Nurse	RN	BPC §2725		Appendix B-4, Standards of Participation

Service	Provider Type	Practitioner	License	Certification	Other Standard
Transitional Case Management	HHA	RN	HHA: CCR Title 22, §§74659–74689		
Transitional Case Management	Professional Corporation	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §§2902-2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Utility Coverage	HCBS Benefit Provider	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §§2902-2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Utility Coverage	HCBS Waiver Registered Nurse	RN	CCR Title 22, §51067 BPC §§2725-2742		Appendix B-4, Standards of Participation
Utility Coverage	HHA	HHA	Public Utilities Commission		Services arranged by agreement with HHA
Utility Coverage	Professional Corporation	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §§2902-2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Waiver Service Coordination	HCBS Benefit Provider	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §§2902-2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation
Waiver Service Coordination	HCBS Waiver Registered Nurse	Registered Nurse	CCR Title 22, §51067 BPC §§2725-2742		Appendix B-4, Standards of Participation
Waiver Service Coordination	HHA	Registered Nurse	CCR Title 22, §§74659–74689 CCR Title 22, §51067; BPC §§2725-2742		
Waiver Service Coordination	Professional Corporation	MFT, Licensed Psychologist, or LCSW	MFT: BPC §4980(b), §4980.02, §4980.40 Licensed Psychologist: BPC §§2902-2903 LCSW: BPC §4996.9		Appendix B-4, Standards of Participation

B. Assurance that Requirements are Met

The State assures that the standards of any State licensure or certification and/or training requirements are met for services or for individuals furnishing services provided under the waiver.

C. Provider Requirements Applicable to Each Service

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. Freedom of Choice

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of treatment.

Appendix B-3, Keys Amendment Standards for Board and Care Facilities

Keys Amendment Assurance:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which HCBS services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

Applicability of Keys Amendment Standards

Check one:

_____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__X__ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

Appendix B-4, Standards of Participation

Home and Community-Based Services Waiver RN or LVN

Under the IHMC Waiver, the role of a HCBS Waiver Nurse Provider is to provide:

- Case management – HCBS Waiver RN only
- Family Training – HCBS Waiver RN only
- Waiver service coordination – HCBS Waiver RN only
- Transitional Case Management – HCBS Waiver RN only
- Private Duty Nursing – HCBS Waiver RN and LVN
- Respite Care – HCBS Waiver RN and LVN
- Utility Coverage – HCBS Waiver RN only

1. Definitions:

   a. "HCBS Waiver Nurse Provider " means a Registered Nurse or a Licensed Vocational Nurse (LVN), who provides HCBS Waiver RN or LVN services, as defined in subsection A.2, below, and, in this capacity, is not employed by or otherwise affiliated with a home health agency or any other licensed health care provider, agency, or organization. A Home and Community-Based Services (HCBS) Waiver RN or LVN may be a parent, stepparent, foster parent of a minor, a spouse, or legal guardian of the individual only under the following circumstances: there are no other available providers, the individual lives in a rural area or the cost neutrality for waiver services can be established and/or maintained by only using this individual. MCOD-IHO may require additional documentation to support requests of this nature. Documentation required before MCOD-IHO can authorize such request, is a written explanation of the attempts made to enlist and retain a HCBS Waiver Nurse Provider, such as a posting classified advertisements, contacting Professional Corporations who employ individuals who qualify as WSC providers as described in Appendix B-4, and a description of other efforts employed to locate a suitable provider. The explanation should also document the outcome of interviews with potential providers and the reasons the applicant was not hired or refused employment, if offered.

   b. "HCBS RN or LVN services" means private duty nursing services, as defined in subsection A.3, below, Case Management, Respite care, Waiver Service Coordination, Transitional Case Management, and Utility coverage as described in Appendix B-1, in this waiver, provided to a beneficiary in his/her home or place of residence by an HCBS RN or LVN, as defined in subsection A.1, above, within his/her scope of practice. Such services shall not include nursing services provided in a licensed health facility.

   c. "Private duty nursing services" means services provided by a Registered Nurse or a Licensed Vocational Nurse, which are more individual and continuous than those routinely available through a home health agency as in part-time or intermittent care on a limited basis.

d. "Medi-Cal Consultant" means either a Registered Nurse or Physician, who is licensed to practice in the State and is an employee of MCOD-IHO.

e. "Education and/or training requirements" means any type of formal instruction related to the care needs of the individual for whom services are being requested. Examples of this could include certifications in a particular field, appropriate to the licensure status of the nurse; or continuing education units in the needs of the beneficiary such as wound or pain management.

f. "Evaluation of theoretical knowledge and manual skills" means an assessment conducted by the registered nurse (RN) of the licensed vocational nurse (LVN) in which the LVN is able to demonstrate competency in the provision of skilled nursing services. Examples of this could include having the LVN verbalize requirements for a certain procedure or process; having the RN review a certain task, demonstrate the task and then observing the LVN perform the tasks as prescribed on the POT. This evaluation would need to be documented and provided to MCOD-IHO as indicated.

Requirements of the Home and Community-Based Services Waiver RN:

1. Registered Nurse (RN) acting as the direct care provider:

    a. The initial Treatment Authorization Request (TAR) shall be accompanied by all of the following documentation:

        i. Current license to practice as an RN in the State of California.

        ii. Current Basic Life Support (BLS) certification.

        iii. Written evidence, in a format acceptable to the Department, of training or experience, which shall include at least one of the following:

            A. A minimum of 1000 hours of experience in the previous two years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT. At least 500 of the 1000 hours shall be in a hospital medical-surgical unit.

            B. A minimum of 2000 hours of experience in the previous three years, in an acute care hospital caring for individuals with the care need(s) specified on the TAR and POT.

            C. A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) specified on the TAR and POT.

            D. A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of the Department, would demonstrate appropriate knowledge, skill and ability in caring for individuals with the care needs specified on the TAR and Plan of Treatment.

        iv. A detailed POT that reflects an appropriate nursing assessment of the beneficiary, interventions, and the physician's orders.

A. The appropriateness of the nursing assessment and interventions shall be determined by the Medi-Cal consultant based upon the beneficiary's medical condition and care need(s).

B. The POT shall be signed by the beneficiary, the RN and the beneficiary's physician, and shall contain the dates of service.

v. Signed release form from the beneficiary's physician, which shall specify both of the following:

A. The physician has knowledge that the RN providing care to the beneficiary is doing so without the affiliation of a home health agency or other licensed health care agency of record.

B. The physician is willing to accept responsibility for the care rendered to the beneficiary.

vi. Written home safety evaluation, in a format acceptable to the Department that demonstrates that the beneficiary's home environment supports the health and safety of the individual. This documentation shall include all of the following:

A. The area where the beneficiary will be cared for will accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies necessary to maintain the individual in the home in comfort and safety, and to facilitate the nursing care required.

B. Primary and back-up utility, communication, and fire safety systems and devices are installed and available in working order, which shall include grounded electrical outlets, smoke detectors, fire extinguisher, telephone, and notification of utility, emergency, and rescue systems that a person with special needs resides in the home.

C. The home complies with local fire, safety, building, and zoning ordinances, and the number of persons residing in the home does not exceed that permitted by such ordinances.

D. All medical equipment, supplies, primary and back-up systems, and other services and supports, identified in the POT, are in place and available in working order, or have been ordered and will be in place at the time the beneficiary is placed in the home.

vii. Medical information that supports the request for the services. May include a history and physical completed by the beneficiary's physician within the previous three months for an individual under the age of 21 and within the previous six months for an individual 21 years of age or older. If the last history and physical was completed outside of the respective timeframes, the history and physical shall be accompanied by documentation of the most recent office visit which shall contain a detailed summary of medical findings that includes a body systems examination.

b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

i. Evidence of renewal of BLS certification and RN licensure prior to expiration.

ii. Written evidence, in a format acceptable to the Department, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

iii. Written evidence, in a format acceptable to the Department, of on-going contact with the beneficiary's physician for the purpose of informing the physician of the individual's progress, updating or revising of the POT, and renewal of physician orders.

iv. Updated POT that reflects ongoing nursing assessment and interventions, and updated physician orders. The updated POT shall be signed by the beneficiary's physician, the RN, the beneficiary and will contain the dates of service.

2. RN case manager, waiver service coordinator, transitional case manager and/or supervisor acting as the supervisor for an Home and Community-Based Services Waiver, LVN who is a Licensed Vocational Nurse (LVN):

   a. The initial TAR shall be accompanied by all of the following documentation:

      i. Current license to practice as an RN in the State of California.

      ii. Current BLS certification.

      iii. Written evidence, in a format acceptable to the Department, of training or experience, as specified in section B, subsection 1(a)(iii) "requirements of the Home and Community-Based Services Waiver, LVN", above.

      iv. Written evidence, in a format acceptable to the Department, of training or experience providing case management, service coordination, and/or supervision or delegating nursing care tasks to an LVN or other subordinate staff.

      v. Detailed POT, as specified in section B, subsection 1(a)(iv) "requirements of the Home and Community-Based Services Waiver, LVN", above.

      vi. Written summary, in a format acceptable to the Department, of nursing care tasks that have been delegated to the LVN.

   b. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

      i. Evidence of renewal of BLS certification and RN licensing prior to expiration.

      ii. Written summary, in a format acceptable to the Department, of all case management, service coordination and/or supervisory activities which shall include all of the following:

         A. Evaluation of the LVN's theoretical knowledge and manual skills needed to care for the individual for whom services have been requested.

         B. The training provided to the LVN, as needed, to ensure appropriate care to the beneficiary for whom services have been requested.

C. Monitoring of the care rendered by the LVN, which shall include validation of post-training performance.

D. Any change in the nursing care tasks delegated to the LVN.

E. Evaluation of the case management and/or waiver coordination activities provided.

iii. Written evidence of ongoing contact with the beneficiary's physician, as specified in section B., subsection 1(b)(iii), "requirements of the Home and Community-Based Services Waiver RN", above.

iv. Updated POT, as specified in section B, subsection 1(b)(iv), "requirements of the Home and Community-Based Services Waiver", above.

LVN acting as the direct care provider:

1. The initial TAR shall be accompanied by all of the following documentation:

   a. Current license to practice as an LVN in the State of California.

   b. Current BLS certification.

   c. Name and RN license number of the individual who will be providing ongoing supervision. Such supervision shall be required at a minimum of two hours per calendar month.

   d. Written evidence, in a format acceptable to the Department, of training or experience, as specified in section B, subsection 1(a)(iii), "requirements of the Home and Community-Based Services Waiver, LVN", above.

   e. Copy of the detailed POT that reflects the RN nursing assessment of the beneficiary and the physician's orders. The POT shall be signed by the supervising RN, the beneficiary's physician, the beneficiary, and the LVN.

   f. Written home safety evaluation, in a format acceptable to the Department, as specified in section B, subsection 1(a)(vi), "requirements of the Home and Community-Based Services Waiver, LVN", above.

   g. Medical information, as specified in section B., subsection 1(a)(vii), "requirements of the "Home and Community-Based Services Licensed Nurse provider", above.

2. All subsequent reauthorization TARs shall be accompanied by all of the following documentation, as specified:

   a. Evidence of renewal of BLS certification and LVN licensure prior to expiration.

   b. Written evidence, in a format acceptable to the Department, of on-going education or training caring for the type of individual for whom services are being requested, at least once per calendar year.

   c. Copy of the updated POT that reflects ongoing RN nursing assessment and updated physician orders. The POT shall be signed by the supervising RN, the beneficiary's physician, the beneficiary, and the LVN, and shall contain the dates of service.

3. A TAR or similar request must be approved in advance by MCOD-IHO and shall be required for each Home and Community-Based Services Waiver, LVN service request. Initial authorization shall be granted for a period of up to 90 days, and reauthorization shall be granted for periods of up to 180 days.

4. The Home and Community-Based Services Waiver LVN shall agree to notify MCOD-IHO and the beneficiary or his/her legal guardian, in writing, at least thirty (30) days prior to the effective date of termination when the Home and Community-Based Services Waiver, LVN intends to terminate Home and Community-Based Services Waiver, LVN services. This time period may be less than thirty (30) days if there are immediate issues of health and safety for either the nurse or the beneficiary, as determined by the MCOD-IHO.

Any subsequently adopted laws or regulations that exceed the HCBS waiver service provider participation requirements shall supersede the HCBS waiver service provider requirements and shall be applicable to all HCBS waiver service providers. Any changes to these Standards of Participation in response to legislative or regulatory actions will require amendment of this waiver and CMS approval.

Appendix B-4, Standards of Participation

Marriage and Family Therapist

The In-Home Medical Care (IHMC) Home and Community Based Services (HCBS) waiver administered by In-Home Operations (IHO) identify multiple providers for the provision of waiver services. A Marriage and Family Therapist (MFT) is an individual who is enrolled and provides services under the IHMC Waiver and who meets and maintains the Standards of Participation (SOP) minimal qualifications for a Marriage and Family Therapist.

Under the IHMC Waiver, the role of a MFT as a HCBS Waiver Service Provider is to provide:

- Case management and/or
- Waiver service coordination
- Transitional case management
- Utility Coverage

A MFT who functions as a HCBS Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a MFT in the State of California.

2. Have work experience that includes, at least, either:

   a. A minimum of 1000 hours of post-licensure experience in providing case management services to the physically and/or developmentally disabled community, through an organization or agency, for the case management services as specified on the Treatment Authorization Request (TAR) and as reflected on the Plan of Treatment (POT). Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services; or,

   b. A minimum of 1000 hours of post-licensure experience as an independent provider in providing case management to the physically and/or developmentally disabled community as specified on the TAR and POT. Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services.

      The MFT must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by IHO.

3. Provide case management, waiver service coordination, or transitional case management services consistent with the physician's orders and the POT as authorized by IHO and within the MFT's scope of practice as follows:

   a. Develop the POT consistent with the assessment of the beneficiary and the physician's orders for care. Collaborate with the beneficiary's physician in the development of the POT to ensure the beneficiary's medical care needs are addressed. The POT will identify

all of the services rendered to meet the needs of the beneficiary, the providers of those services and the expected outcomes.

b. Within the MFT's scope of practice, facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the physician of the beneficiary's status and update or revise the POT as directed by the physician to reflect the medical needs of the beneficiary, as determined by the physician. Assist the beneficiary in accessing medical care services that are beyond the MFT's scope of practice. The POT is updated and signed by the physician no less frequently than once every six months.

Any subsequently adopted laws or regulations that exceed the HCBS waiver service provider participation requirements shall supersede the HCBS waiver service provider requirements and shall be applicable to all HCBS waiver service providers. Any changes to these Standards of Participation in response to legislative or regulatory actions will require amendment of this waiver and CMS approval.

Appendix B-4, Standards of Participation

Licensed Psychologist

The In-Home Medical Care (IHMC) Home and Community Based Services (HCBS) waiver administered by In-Home Operations (IHO) identify multiple providers for the provision of waiver services. A licensed Psychologist is an individual who is enrolled and provides services under the IHMC Waiver and who meets and maintains the Standards of Participation (SOP) minimal qualifications for a Licensed Psychologist.

Under the IHMC Waiver, the role of a Licensed Psychologist as a HCBS Waiver Service Provider is to provide:

- Case management and/or
- Waiver service coordination
- Transitional case management
- Utility Coverage

1. A Licensed Psychologist who functions as an HCBS Waiver Service Provider shall:

   a. Have and maintain a current, unsuspended, un-revoked license to practice as a Licensed Psychologist in the State of California.

   b. Have work experience that includes, at least, either:

      i. A minimum of 1000 hours of post-licensure experience in providing case management services to the physically and/or developmentally disabled community, through an organization or agency, for the case management services as specified on the Treatment Authorization Request (TAR) and as reflected on the Plan of Treatment (POT). Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services; or,

      ii. A minimum of 1000 hours of post-licensure experience as an independent provider in providing case management to the physically and/or developmentally disabled community as specified on the TAR and POT. Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services.

   c. The Licensed Psychologist must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by IHO.

   d. Provide case management, waiver service coordination, or transitional case management services within the scope of practice of a Licensed Psychologist consistent with the physician's orders and the POT as authorized by IHO as follows:

i. Develop the POT consistent with the assessment of the beneficiary and the physician's orders for care. Collaborate with the beneficiary's physician in the development of the POT to ensure the beneficiary's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the beneficiary, the providers of those services and the expected outcomes.

ii. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the physician of the beneficiary's status and update or revise the POT as directed by the physician to reflect the medical needs of the beneficiary, as determined by the physician. Assist the beneficiary in accessing medical care services that are beyond the Licensed Psychologist's scope of practice. The POT must be updated and signed by the physician no less frequently than once every six months.

Any subsequently adopted laws or regulations that exceed the HCBS waiver service provider participation requirements shall supersede the HCBS waiver service provider requirements and shall be applicable to all HCBS waiver service providers. Any changes to these Standards of Participation in response to legislative or regulatory actions will require amendment of this waiver and CMS approval.

Appendix B-4, Standards of Participation

Licensed Clinical Social Worker

The In-Home Medical Care (IHMC) Home and Community Based Services (HCBS) waiver administered by In-Home Operations (IHO) identify multiple providers for the provision of waiver services. This is specified in the Appendix B-2 in which the providers, the services they provide and the certification required is defined (Appendix B-2, Licensing and Certification Chart).

The IHMC HCBS waiver administered by In-Home Operations (IHO) identify multiple providers for the provision of waiver services. A Licensed Clinical Social Worker (LCSW) is an individual who is enrolled and provides services under the IHMC waiver and who meets and maintains the Standards of Participation (SOP) minimal qualifications for a LCSW.

Under the IHMC Waiver, the role of a LCSW as a HCBS Waiver Service Provider is to provide:

- Case management
- Waiver service coordination
- Transitional case management
- Utility Coverage

A LCSW who functions as an HCBS Waiver Service Provider shall:

1. Have and maintain a current, unsuspended, un-revoked license to practice as a LCSW in the State of California.
2. Have work experience that includes, at least, either:
   a. A minimum of 1000 hours of post-licensure experience in providing case management services to the physically and/or developmentally disabled community, through an organization or agency, for the case management services as specified on the Treatment Authorization Request (TAR) and as reflected on the Plan of Treatment (POT). Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services; or,
   b. A minimum of 1000 hours of post-licensure experience as an independent provider in providing case management to the physically and/or developmentally disabled community as specified on the TAR and POT. Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services.

      The LCSW must provide and maintain adequate documentation of the minimum hours of work experience for inspection and review by IHO.

3. Provide case management, waiver service coordination, or transitional case management services within the scope of practice of a LCSW consistent with the physician's orders and the POT as authorized by IHO, as follows:

    a. Develop the POT consistent with the assessment of the beneficiary and the physician's orders for care. Collaborate with the beneficiary's physician in the development of the POT to ensure the beneficiary's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the beneficiary, the providers of those services and the expected outcomes.

    b. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the physician of the beneficiary's status and update or revise the POT as directed by the physician to reflect the medical needs of the beneficiary, as determined by the physician. Assist the beneficiary in accessing medical care services that are beyond the LCSW's scope of practice. The POT is updated and signed by the physician no less frequently than once every six months.

Any subsequently adopted laws or regulations that exceed the HCBS waiver service provider participation requirements shall supersede the HCBS waiver service provider requirements and shall be applicable to all HCBS waiver service providers. Any changes to these Standards of Participation in response to legislative or regulatory actions will require amendment of this waiver and CMS approval.

Appendix B-4, Standards of Participation

Professional Corporation

The In-Home Medical Care (IHMC) Home and Community Based Services (HCBS) waiver administered by In-Home Operations (IHO) identify multiple providers for the provision of waiver services. A professional Corporation is a provider that employs individuals who provide services authorized under the IHMC Waiver and is enrolled as an HCBS Waiver Professional Corporation provider in the IHMC Waiver, and meets and maintains the Standards of Participation (SOP) minimal qualifications for a Professional Corporation.

Under the IHMC Waiver, the role of the Professional Corporation is to permit its licensed employees within the scope of their practice to provide:

- Case management and/or
- Waiver service coordination
- Transitional case management
- Utility Coverage

1. The following are the licensed persons permitted to provide the above listed services as Professional Corporations to waiver beneficiaries under the terms of the HCBS waiver:

    a. Licensed Psychologists (See Business and Professions Code section 2900, et seq.) operating a Professional Corporation pursuant to Corporations Code section 13400, et seq.;

    b. Licensed Clinical Social Workers (LCSW) (See Business and Professions Code section 4996, et seq.); operating a Professional Corporation pursuant to Corporations Code section 13400, et seq., and

    c. Marriage and Family Therapists (MFT) (See Business and Professions Code section 4980, et seq.) operating as a Professional Corporation pursuant to Corporations Code section 13400, et seq.

2. A Professional Corporation who functions as a HCBS Waiver Service Provider shall:

    a. Be currently and continuously incorporated in the State of California as a professional corporation, pursuant to Corporations Code section 13400, et seq., or if a foreign professional corporation, be currently and continuously incorporated in its state of incorporation and have filed in California a Statement and Designation of a Professional Foreign Corporation. Good standing of a domestic or foreign professional corporation must be maintained as long as the professional corporation is enrolled as an HCBS waiver provider. All Professional Corporations enrolling as HCBS waiver providers must provide a Certificate of Status of good standing to do business in the State of California (available from the Secretary of State's Office) upon enrollment and provide a current certificate of registration (pursuant to Corporations Code section 13401(b)

provided by the governmental agency regulating the profession. Professions regulated by the Board of Behavioral Sciences that organize as professional corporations are exempt from providing the certificate of registration. (Corporations Code section 13401(b)).

b. Have and maintain a current, unsuspended, un-revoked license to practice business in the State of California.

c. Employ licensed persons as specified above who will render waiver services to waiver beneficiaries as requested and authorized and who meet the following criteria:

d. Employ only licensed persons with a current, unsuspended, un-revoked license to practice in the State of California. The Professional Corporation must maintain records of licensing for inspection and review by IHO. The professional corporation must notify IHO in writing of any change in licensure status of its licensed employees within 30 days of the change of licensure status.

e. Employ licensed persons who have documented work experience that includes, as least, either:

   i. A minimum of 1000 hours of post-licensure experience in providing case management services to the physically and/or developmentally disabled community, through an organization or agency, for the case management services as specified on the Treatment Authorization Request (TAR) and as reflected on the Plan of Treatment (POT). Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services; or,

   ii. A minimum of 1000 hours of post-licensure experience as an independent provider in providing case management to the physically and/or developmentally disabled community as specified on the TAR and POT. Such experience shall have been acquired in the two years immediately preceding the submission of the TAR requesting case management, waiver service coordination, or transitional case management services.

   The Professional Corporation must maintain adequate documentation of the minimum hours of work experience for each of its licensed persons for inspection and review by IHO.

f. Provide case management, waiver service coordination, or transitional case management services consistent with the physician's orders and the POT within the scope of the licensed person's scope of practice as follows:

   i. Develop the POT consistent with the assessment of the beneficiary and the physician's orders for care. Collaborate with the beneficiary's physician in the development of the POT to ensure the beneficiary's medical care needs are addressed. The POT will identify all of the services rendered to meet the needs of the beneficiary, the providers of those services, and the expected outcomes; and

   ii. Facilitate the process of assessing the beneficiary at the frequency described in the POT for progress and response to the POT. Inform the physician of the beneficiary's

status and update or revise the POT as directed by the physician to reflect the medical needs of the beneficiary, as determined by the physician. Assist the beneficiary in accessing medical care services that are beyond the licensed person's scope of practice. The POT must be updated and signed by the physician no less frequently than once every six months.

Any subsequently adopted laws or regulations that exceed the HCBS waiver service provider participation requirements shall supersede the HCBS waiver service provider requirements and shall be applicable to all HCBS waiver service providers. Any changes to these Standards of Participation in response to legislative or regulatory actions will require amendment of this waiver and CMS approval.

Appendix B-4, Standards of Participation

Home and Community-Based Services Nursing Facility (Congregate Living Health Facility)

The Home and Community-Based Services (HCBS) waiver programs provide services and support to eligible waiver beneficiaries who require institutional level of care and choose to receive their medical care services in a home or community setting. As a HCBS waiver service provider, a Congregate Living Health Facility (CLHF) will provide a home like setting for individuals enrolled in a Medi-Cal IHMC Waiver who choose a CLHF as their place of residence. As a HCBS waiver service provider, the CLHF shall meet all applicable licensing standards and will be subject to these Waiver Provider Standards of Participation (SOP) and will adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS) approved waiver.

As a Medi-Cal HCBS waiver provider, a CLHF waiver provider is a residential facility with a non-institutional, homelike environment, having no more than six beds and provides inpatient care that includes the following array of services: medical supervision, 24-hour skilled nursing services and supportive care, pharmacy, dietary, social, recreational and services for waiver beneficiaries who meet the medical level of care criteria of the appropriate waiver and are persons whose medical condition(s) are within the scope of licensure for CLHFs as follows: : persons who are mentally alert and physically disabled, persons who have a diagnosis of terminal illness, persons who have a diagnosis of a life-threatening illness or persons who are catastrophically and severely disabled. The primary need of CLHF residents shall be the availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis.

1. Legal Authority and Requirements

   CLHFs shall be licensed in accordance with Health &Safety Code sections 1250(i), 1267.12, and 1267.13, 1267.16, 1267.17, and 1267.19 and shall provide skilled nursing waiver services in accordance with California Code of Regulations (CCR) Title 22 sections 51003 and 51344 and the waiver document.

   CLHFs must be enrolled as a Medi-Cal Waiver provider and shall meet the standards specified in the CCR, Title 22, sections 51200(a), 51000.30 through 51000.55.

   Any subsequently adopted laws or regulations that exceed the CLHF waiver provider participation requirements shall supercede the CLHF waiver provider requirements and shall be applicable to all CLHF waiver providers.

2. Physical Plant and Health and Safety Requirements

   To ensure the health and safety of the HCBS waiver beneficiary the physical plant of the CLHF shall conform to the H&S Code section 1267.13, as described in part in the following:

a. Obtain and maintain a valid fire clearance from the appropriate authority having jurisdiction over the facility; based on compliance with state regulations concerning fire and life safety, as adopted by the State Fire Marshall.

b. The facility shall be in a homelike, residential setting. The facility shall provide sufficient space to allow for the comfort and privacy of each resident and adequate space for the staff to complete their tasks.

c. Common areas in addition to the space allotted for the residents' sleeping quarters, shall be provided in sufficient quantity to promote the socialization and recreational activities of the residents in a homelike and communal manner.

d. The residents' individual sleeping quarters will allow sufficient space for safe storage of their property, possessions, and furnishings and still permit access for the staff to complete their necessary health care functions. Not more than two residents shall share a bedroom.

e. Bathrooms of sufficient space and quantity shall be provided to allow for the hygiene needs of each resident and the ability of the staff to render care without spatial limitations or compromise. No bathroom shall be accessed only through a resident's bedroom.

f. The facility will be maintained in good repair and shall provide a safe, clean, and healthy environment at all times. All persons shall be protected from hazards throughout the premises.

3. CLHFs Providing Home and Community-Based Services

As a provider of HCBS waiver services, a CLHF shall employ a variety of providers and render services as indicated below. The individuals providing waiver services to HCBS Waiver beneficiaries shall meet all licensing requirements as specified in California Business and Professions Code and all the standards of participation of the HCBS Waiver. The primary category of service provided by a CLHF is nursing services, which must be available to HCBS waiver clients on a 24 hours, 7 days a week basis.

4. Nursing Services

Pursuant to H&S Code section 1267.13(o)(2)(B) and (o)(2)(C), CLHFs shall provide nursing services provided by a Registered Nurse (RN), Licensed Vocational Nurse (LVN), and a Certified Nurse Assistant (CNA) or equivalent unlicensed provider. There shall be a minimum of two staff members (1, 2, and 3 below) awake, alert, and on duty at all times to provide for the residents of the CLHF. At no time can two CNAs or equivalent unlicensed providers be solely responsible for patients, as there must always be a RN or LVN present and "on duty". No nursing personnel shall be assigned housekeeping or dietary duties, such as meal preparation.

a. Registered Nurse (RN)

i. A RN will be available on-call to the facility with a response time of thirty minutes or less at all times that a RN is not on the premises.

ii. The RN shall visit each resident for a minimum of two hours, twice a week, or longer as necessary to meet the resident's patient care needs.

b. Licensed Vocational Nurse (LVN)

i. A LVN shall be in the facility and "on duty" at any time that a RN is not in the facility.

c. Certified Nurse Assistant (CNA) or equivalent unlicensed provider

i. A CNA or persons with similar training and experience as determined by the Department of Health Services (DHS) Licensing and Certification (L&C) may be available in the facility to assist the skilled nursing staff (RN and LVN) to meet the requirement of two staff members in the facility.

The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs.

5. Other Health Related Services

a. In addition to the skilled nursing services and pursuant to H&S Code sections 1250(i) and 1267.13, CLHFs will provide or arrange for the following basic services to be provided to individuals enrolled in the HCBS waiver, as part of the per diem rate paid to CLHF waiver providers:

- Medical supervision
- Case Management
- Pharmacy consultation
- Dietary consultation
- Social Services
- Recreational services
- Transportation to and from medical appointments
- Housekeeping and laundry services
- Cooking and shopping

b. H&S Code section 1267.13(o)(3) states, "The facility shall provide appropriately qualified staff in sufficient numbers to meet patient care needs." In addition to nursing care, a facility shall provide professional, administrative, or supportive personnel for the health, safety, and special needs of the patients.

c. Pursuant to H&S Code section 1267.12, "All persons admitted or accepted for care by the CLHF shall remain under the care of a physician and surgeon who shall see the resident at least every 30 calendar days or more frequently if required by the resident's medical condition."

d. As a HCBS waiver service provider, each HCBS waiver enrolled individual will be assessed for needed or required services as identified by the individual, their legal representative, physician, family, caregivers, and/or other individuals at the request of the individual. The CLHF will establish a POT to address how these services will be provided, the frequency of the services and identify the provider for those services that are not included in the CLHF's per diem rate under this waiver. The CLHF will be responsible for arranging for the following services, which may include but are not limited to:

- Counseling services provided by a Licensed Clinical Social Worker
- Occupational therapy provided by an Occupational Therapist
- Physical therapy provided by a Physical Therapist
- Speech therapy provided by a Speech Therapist
- Education and training of the HCBS waiver individual to self-direct his/her care needs and/or the education and training of their identified caregivers (who are not CLHF employees) on their care needs.
- Assessment for and repair of Durable Medical Equipment
- State Plan Personal Care Services or Home and Community Based Personal Care (HCBSPC) as described in the waiver when off site from the CLHF if such care is not duplicative of care required to be provided to the beneficiary by the CLHF (i.e., not for care to and from medical appointments). State Plan or HCBSPC benefit providers will not be paid for care that is duplicative of the care being provided by the CLHF.

6. Documentation

a. All HCBS waiver services rendered by the CLHF shall require prior authorization and reauthorization in accordance with CCR Title 22, section 51003.

b. A Treatment Authorization Request (TAR) shall be prepared by the CLHF and submitted to Medi-Cal Operations Division, In-Home Operations (MCOD-IHO) for each beneficiary residing in a CLHF that renders HCBS waiver services. The initial TAR for each beneficiary shall be accompanied by a RN developed assessment of care needs, home safety evaluation, and a Plan of Treatment (POT) signed by a physician. The initial TAR submitted by the CLHF shall include a copy of the current facility license. TARs submitted for reauthorization shall be accompanied by an updated physician signed POT and a renewed facility license, as appropriate.

c. Each CLHF HCBS Waiver service provider shall maintain a medical record chart for each beneficiary in residence. This medical record shall include documentation regarding all contact made with CLHF professional personnel, current POTs, referral requests and outcomes of said referrals and shall be available to appropriate DHS staff for any scheduled or unscheduled visit. All CLHF documentation shall be maintained in compliance with the applicable Federal and State laws, Medi-Cal Provider Standards of Participation, and shall be retained by the CLHF for three

years. The CLHF shall also maintain records to document the nursing staff requirements (see Nursing Services above) of these standards of participation have been met and have those records available for inspection or review by IHO upon request at any time an enrolled waiver beneficiary is receiving services through a CLHF.

7. Quality Control/Quality Assurance

   Quality control/quality assurance reviews will be in accordance with the Medi-Cal Operations Division/In-Home Operations (MCOD-IHO) Quality Assurance Plan, as described in the CMS approved waiver.

8. Training Requirements

   As a licensed CLHF, HCBS waiver service provider, and pursuant to H&S Code section 1267.13(o)(5), the CLHF shall ensure all CLHF staff shall receive training regarding care appropriate for each beneficiary's diagnoses and their individual needs. The supervisor(s) of licensed and unlicensed personnel will arrange for the training of their staff to be provided by the CLHF. Provision of the training to CLHF staff is a requirement to be enrolled as a HCBS Waiver provider and is not reimbursed by either Medi-Cal or the HCBS Waiver.

Pursuant to the Policies and Procedures of the CLHF and as a HCBS waiver provider, each category of nursing (RN, LVN and CNA) shall meet the training requirements to provide the services specified in the plan of treatment as allowed with the respective scope of practice. DHS Licensing & Certification will determine if the CLHFs policies and procedures are adequate for the provision of supportive health care services to care for residents, such as those who may be ventilator dependent, require a monitor or other specialized medical equipment as ordered by their physician.

As determined by DHS Licensing &Certification, the CLHF is responsible for the orientation and training of all staff that render care. This includes the review of new and existing CLHF policies and procedures and shall be provided on a quarterly basis. Evidence of quarterly training shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor. Training shall be relevant to the care and type of beneficiary served by the CLHF and enrolled in this waiver.

Any subsequently adopted laws or regulations that exceed the HCBS waiver service provider participation requirements shall supersede the HCBS waiver service provider requirements and shall be applicable to all HCBS waiver service providers. Any changes to these Standards of Participation in response to legislative or regulatory actions will require amendment of this waiver and CMS approval.

APPENDIX C - ELIGIBILITY AND POST-ELIGIBILITY

Appendix C-1, Eligibility

Medicaid Eligibility Groups Served

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. _X_ Low-income families with children as described in Section 1931 of the Social Security Act.

2. _X_ SSI recipients (SSI Rules States and 1634 States).

3. ____ Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. _X_ Optional State supplement recipients.

5. _X_ Optional categorically needy aged and disabled who have income at (Check one):

   a. _X_ 100% of the Federal poverty level (FPL).

   b. ____ % Percent of FPL which is lower than 100%.

6. _X_ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

   Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

   a. _X_ Yes b. ____ No

   Check one:

   a. _X_ The waiver covers <u>all</u> individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community.

   b. ____ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

      (1) ___ A special income level equal to:

_____ 300% of the SSI Federal benefit (FBR)

_____ % of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)___ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324)

(4)___ Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)____Aged and disabled who have income at:

a.____ 100% of the FPL

b.____ % which is lower than 100%.

(6)___ All other mandatory and optional groups under the plan are included.

7._X__ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8._X__ All other mandatory and optional groups under the plan are included.

9.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

Appendix C-2, Post-Eligibility

General Instructions

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: It may use the spousal post-eligibility rules under §1924.

Regular Post-Eligibility Rules - §435.726 and §435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC *need* standard for a family of the same size

or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

Spousal Post-Eligibility--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance "which is reasonable in amount for clothing and other personal needs of the individual while in an institution." For institutionalized individuals this amount could be as low as $30 per month, but must be a reasonable amount for clothing and other personal needs of an individual . . . while in an institution. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. Therefore, the $30 PNA may not be a reasonable amount when the waiver recipient is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules *must* use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

Appendix C-3, Community Income and Resource Policies for the Medically Needy

Waiver of Community Income and Resource Policies for the Medically Needy (§§ 1915 (C) (3) and 1902 (A) (10) (C) (I) (Iii) of the Social Security Act).

In addition to using the institutional income and resource rules for the medically needy, we are using this waiver authority to permit a second vehicle exemption for the waiver program. A recipient may claim an exemption for a second vehicle if it was modified to accommodate the physical handicap(s) or medical needs of the individual. Verification shall be by physician's written statement of necessity.

Post Eligibility

Regular Post Eligibility

1(a). _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. § 435.726--States which do not use more restrictive eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level:

(5) _X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.

B.___ The following dollar amount: $_____ (If this amount changes, this item will be revised).

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2 and 3** following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount: $_____ (If this amount changes, this item will be revised).

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

F.____ The amount is determined using the following formula.

G._X_ Not applicable (N/A)

3. Family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount: $_____ (If this amount changes, this item will be revised).

D.____ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

E.____ The amount is determined using the following formula:

F.____ Other

G._X__Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

1(b).____ 209(b) State. A State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction of the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

a. Allowances for the needs of the

1. individual: (check one):

A.____ The following standard included under the State plan (check one):

(1)_____SSI

(2)____ Medically needy

(3)____ The special income level for the institutionalized

(4)____ The following percentage of the Federal poverty level:_____%

(5)____ Other (specify):

B.____ The following dollar amount: $_____ (If this amount changes, this item will be revised).

C.____ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1 is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2 and 3** following.

2. spouse only (check one):

A.____ The following standard under 42 CFR 435.121:

B.____ The medically needy income standard _____;

C.____ The following dollar amount: $_____ (If this amount changes, this item will be revised).

D.____ The following percentage of the following standard that is not greater than the standards above:

_____% of _____.

E.____ The following formula is used to determine the amount:

3. family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount: $_____ (If this amount changes, this item will be revised).

D.____The following percentage of the following standard that is not greater that the standards above: ____% of standard.

E.____ The following formula is used to determine the amount:

F.____ Other

G.____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

A. Allowance for personal needs of the individual: (check one)

(1)____ Institutional PNA: Specify the amount: $_____.

*Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community.

(2) X An amount that is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses. (Check one):

(a)____ SSI Standard

(b)____ Medically Needy Standard

(c)____ The special income level for the institutionalized

(d)____ The following percent of the Federal poverty level: ____%

(e) X Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase.

(f)____The following dollar amount: $_____ (If this amount changes, this item will be revised).

g)___ The following formula is used to determine the needs allowance:

APPENDIX D, ENTRANCE PROCEDURES AND REQUIREMENTS

Appendix D-1, Evaluation of Level of Care

a. Evaluation of Level of Care

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. Qualifications of Individuals Performing Initial Evaluation

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

____ Discharge planning team

____ Physician (M.D. or D.O)

_X_ Registered Nurse, licensed in the State and who is an employee of MCOD-IHO.

____ Licensed Social Worker

____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_X_ Other (Specify): Physician (M.D. or D.O.) licensed in the State and who is an employee of MCOD-IHO.

c. Criteria for Denial of Initial Request for Services

The initial request for IHMC Waiver services shall be denied when:

1. The enrollment cap for the waiver has been met for the current fiscal year (the individual will be placed on a wait list if they so choose)

2. The request does not meet hospital level of care described in this waiver.

3. The cost of the requested services exceeds the institutional cost of IHMC level of care and the beneficiary **does not** agree to a reduction in the requested services. Any reduction in requested services must still provide a program that assists in meeting the beneficiary's health and safety needs.

4. There is not an identified support network system available to the beneficiary and attempts have been made by the HCBS waiver service provider and/or MCOD-IHO to assist in the development/maintenance of this system without success.

5. The beneficiary meets the Nursing Facility Subacute (NF SA) LOC and there is a NF SA facility in their community that will provide inpatient care to the beneficiary. MCOD-IHO staff will advise the beneficiary of the NF SA Waiver services and assist in the transfer of the initial request for services to the NF SA Waiver. If the enrollment cap for the NF SA Waiver has been met for the current fiscal year, the individual will be placed on the NF SA wait list if they so choose.

6. The beneficiary is not able to establish Medi-Cal eligibility

7. The request for services does not meet medical eligibility criteria used to determine IHMC service eligibility as outlined in Title 22, CCR, Sections, 51110, 51137, 51137.1 and 51344.

8. The beneficiary or the authorized representative, to the extent the beneficiary needs support, elects in writing to withdraw the request for services

9. The provider of IHMC Waiver services for the beneficiary is unwilling or unable to assure that the beneficiary is receiving either the quantity or quality of IHMC Waiver services required by the beneficiary's POT and physician orders. In such case, the Department will assist the beneficiary either with finding appropriate waiver providers or with the authorization process for the beneficiary at the otherwise appropriate level of institutional care.

10. The beneficiary or the authorized representative does not agree to reduce the amount of requested private duty nursing services, home health aide services, respite services, and Medi-Cal State Plan Personal Care Services authorized by the Department of Social Services when the combination of these services exceeds 24 hours a day.

11. The beneficiary's condition is not stable, as demonstrated by repeated unplanned hospitalizations.

12. The beneficiary's condition changes such that he/she needs a level of service different from that identified in the previous IHMC Waiver POT or level of care documentation.

13. The beneficiary becomes deceased.

14. The beneficiary or the beneficiary's authorized representative declines waiver services.

15. The beneficiary and/or legal guardian has not selected a waiver service or identified a waiver provider within 180 days of the initial home visit.

When IHMC Waiver services are denied, reduced or terminated by the Department, a Notice of Action will be forwarded to the beneficiary in conformance with 42 CFR Part 431, Subpart E.

Appendix D-2, Reevaluations of Level of Care

a. Reevaluations of Level of Care

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

____ Every 3 months

____ Every 6 months.

____ Every 12 months

_X_ Other (Specify): MCOD-IHO staff will utilize the internally developed Case Management Acuity System to determine the level of intensity for programmatic case management and periodicity for Level of Care redeterminations. This acuity system ranges from 1-4 with 4 requiring the most intensive follow-up and technical assistance from program staff. These evaluations for the level of care will be completed by conducting the visits to the beneficiary's place of residence by MCOD-IHO staff.

- Cases assigned a case management acuity of 1-2 will be seen every 12 months. During the interval months, staff will have periodic contact with the beneficiary and/or the community case management provider to check on status of the beneficiary. Contact information will be documented in the running record of the IHO chart. Based on interim status reports and/or information received from the beneficiary or the community case manager, cases with an acuity level of 1-2 may be seen sooner than the 12-month interval. .

- Cases assigned a case management acuity of 3-4 will be seen every six months

b. Qualifications of Persons Performing Reevaluations

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

____ Physician (M.D. or D.O.)

____ Registered Nurse, licensed in the State

____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

c. Procedures to Ensure Timely Reevaluations

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_____ "Tickler" file

_____ Edits in computer system

__X__ Component part of case management (conducted by MCOD-IHO staff)

__X__ Other (Specify): MCOD-IHO Database Query for next schedule home visit.

d. Criteria for Modification or Termination of IHMC Waiver Services

Requests for reauthorization of IHMC Waiver services shall be modified when any one of the following circumstances occur:

1. The cost of the requested services exceeds the cost of the institutional IHMC level of care and the beneficiary or, if appropriate, the authorized representative does not agree to a reduction in the requested services. The approved services must be cost neutral and must provide a program that assists in meeting the beneficiary's health and safety needs.

2. The beneficiary loses Medi-Cal eligibility.

3. The beneficiary or, if appropriate, the authorized representative to the extent the beneficiary needs support, or the identified provider of services gives a 30 day notice of termination and there are qualified providers of service who have not agreed to provide the requested services for the beneficiary. The MCOD-IHO nurse case manager will assist the beneficiary or the authorized representative in identifying any alternatives that may help meet the medical care needs of the waiver recipient.

4. The MCOD-IHO nurse case manager or other appropriate program staff, in consultation with the beneficiary's primary physician, agrees that the beneficiary's condition has changed to the point that he/she no longer meets the medical eligibility criteria used to determine IHMC Waiver services eligibility.

5. The requested services exceed 24 hours a day of direct care services.

IHMC Waiver services shall be terminated or shall not be reauthorized by the Department when any one of the following circumstances occur:

1. The Department determines that circumstances within control of the beneficiary or the legal guardian pose a threat to the health and safety of the beneficiary.

2. The cost of the requested services exceeds the cost of the institutional IHMC level of care and the beneficiary does not agree to a reduction in the requested services. To be appropriate, the approved waiver services must be cost neutral and must provide for a plan that assists in meeting the beneficiary's health and safety needs.

3. The beneficiary receiving IHMC Waiver services refuses to comply with the primary care physician's orders or POT.

4. The identified support network system available to the beneficiary is no longer in place and attempts have been made by the HCBS waiver service provider and/or MCOD-IHO to assist in the development/maintenance of this system without success.

5. The spouse, parent, designated family member, licensed foster parent, or other responsible individual cannot be identified or is no longer willing or available to assume the responsibility to act as back-up caregiver for the care needs of the beneficiary. The MCOD-IHO nurse case manager will work with the beneficiary and responsible persons to develop a plan of treatment and identify providers so the beneficiary can continue to reside safely in a home-like setting, when possible. Every responsible effort will be made by the MCOD-IHO nurse case manager in establishing case management services for beneficiaries who elect only HCBS PCS benefit."

6. The spouse, parent, designated family member, licensed foster parent, or other responsible individual caregiver refuses to comply with the attending physician's orders or POT.

7. The home/family assessment fails to demonstrate an environment that supports the beneficiary's health and safety, or otherwise is not conducive to the provision of waiver services. Home safety will be determined by a home safety evaluation submitted by the primary provider of services. Additionally, when prescribed home visits are made, home safety will be addressed and documented in the "Home Safety Evaluation" section on the "Case Management Report" (Attachment D-2) used by MCOD-IHO staff. Before denying or terminating services, the provider will put a plan of correction in place. The MCOD-IHO staff will then follow-up to determine if the plan has been effective and what further actions, if any, implemented.

8. The provider of IHMC Waiver services for the beneficiary is unwilling or unable to assure that the beneficiary is receiving either the quantity or quality of IHMC Waiver services required by the beneficiary's POT and physician orders. In such case, the Department will assist the beneficiary either with finding appropriate waiver providers or with the authorization process for the beneficiary at the otherwise appropriate level of institutional care.

9. The beneficiary's condition is not stable, as demonstrated by repeated unplanned hospitalizations.

10. The beneficiary's condition changes such that he/she needs a level of service different from that identified in the previous IHMC Waiver POT or level of care documentation.

11. The beneficiary or his/her authorized representative elects in writing to decline IHMC Waiver services.

12. The beneficiary becomes deceased.

When IHMC Waiver services are denied, reduced or terminated by the Department, a Notice of Action will be forwarded to the beneficiary in conformance with 42 CFR Part 431, Subpart E.

Appendix D-3, Maintenance of Records

a. Maintenance of Records

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

   ____ By the Medicaid agency in its central office

   ____ By the Medicaid agency in district/local offices

   _X_ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

   _X_ By the case managers employed by MCOD-IHO.

   _X_ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

   ____ By service providers

   ____ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. Copies of Forms and Criteria for Evaluation/Assessment

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

The criteria used for waiver level of care is determined by criteria established in Title 22, CCR, Division 3, Sections 51120, 51124, 51334 and 51335 and information submitted on the Treatment Authorization Requests which support medical necessity for the services as defined in Title 22, CCR, Section 51003. This information is used for initial and ongoing reevaluations of all services authorized under the auspices of the IHMC Waiver.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

_X_ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

c. Criteria by Which the Level of Service Decision is Made

The IHMC Waiver target population consists of Medi-Cal eligible disabled persons whom the attending primary care physician and the Medi-Cal consultant agree would, as a practical matter, in the absence of the waiver, be expected to require at least 90 consecutive days of the level of service provided in an acute care hospital.

1. The Medi-Cal consultant shall be a physician or a Registered Nurse.

2. The population targeted for this waiver includes beneficiaries for whom inpatient nursing facility care is currently authorized at the IHMC level and is expected to be authorized for at least 90 consecutive days, and beneficiaries who are in the community but who, in the absence of the waiver, are likely to require institutionalization in an acute care hospital at the IHMC level of care for at least 90 consecutive days.

3. A determination of medical eligibility for this waiver shall be based upon all of the following requirements:

   A completed level of care assessment for IHMC Waiver services. An IHMC Waiver services assessment means an assessment, conducted by the Department. The initial assessment is documented on the Intake Medical Summary form (Attachment 1). The IHMC Waiver services assessment enables the Department to determine, among other things, the following:

   i. Identification of an attending physician who provides beneficiary-specific written orders;

   ii. A complete and accurate written medical record exists, including diagnoses, history and physical assessment, treatment plan and prognosis;

   iii. A medical need exists for the level of services requested; and

   iv. A determination that the services to be provided will maintain program cost neutrality.

b. The requested services do not exceed 24 hours a day of direct care services.

Appendix D-3, Attachments

Attachment 1,	**Intake Medical Summary (IMS) Form**
Attachment 2,	**Case Management Report (CMR) Form**
Attachment 3,	**Instructions for Completing IMS and CMR Forms**
Attachment 4,	**Case Management Acuity System**
Attachment 5,	**Home Safety Evaluation Form and Instructions**
Attachment 6,	**Menu of Home and Community-Based Waiver Services (MOHS) Forms**

Appendix D-3, Attachment

Attachment 1, Intake Medical Summary (IMS) Form

In-Home Operations – **INTAKE MEDICAL SUMMARY (IMS):**	**IHO Region:** ❑ **North** ❑ **South**
Name:	**Date of Visit:**
SSN:	**Case Manager:**

Directions to Home

Home Visit Summary

Purpose of Visit:

Persons Present:

Living Arrangements:

Chart and POT Review:

Staffing Issues:

Medical History:

Review of Home Safety
(please place an X next to the appropriate answers)

In-Home Environment:	☐ Adequate	☐ Not Adequate
Utilities:	☐ Working	☐ Not Working
Fire Extinguisher:	☐ Yes	☐ No
Smoke Detector:	☐ Yes	☐ No
Pest Problems:	☐ Yes	☐ No

Home Entrance/Exit:

Emergency Evacuation Plan:

Durable Medical Equipment & Supplies:

Review of Systems: List DME in each system review section, as appropriate

Weight:

Neurological:

Respiratory:

Cardiovascular:

Genito-Urinary:

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):

IHO Region: ☐ **North** ☐ **South**

Name: **Date of Visit:**
SSN: **Case Manager:**

Gastro-Intestinal:

Integumentary:

Musculoskeletal:

Psychosocial:

Review of Other Agencies, Programs, and Services Provided:

Report(s) obtained ☐ Yes ☐ No
List report(s) and date:

Issues/Plan for Resolution

Issues:

➢

Plan for Resolution:

➢

(Please place an X next to the appropriate type(s) of referrals which apply)

Referrals		**Date**	**Referrals**		**Date**	**Referrals**		**Date**
Physical Therapy	☐	_____	Enterostomal Therapy	☐	_____	APS	☐	_____
Occupational Therapy	☐	_____	Medical Social Worker	☐	_____	CPS	☐	_____
Speech Therapy	☐	_____	AAC Device	☐	_____	L&C	☐	_____
Other:	☐	_____	Other:	☐	_____			_____

Comments regarding referrals:

Justification for Program Level of Care and Level of Case Management

Based upon the information contained in this report, the ( ) facility alternative level of care (LOC) is

Request for change in Menu of Health Services: ☐ No ☐ Yes: If yes, update menu of services accordingly.

Print Name of NEII

Signature of NEII **Date report completed**

Print Name/Title Second Opinion-Reviewer of LOC Determination

Signature of Second Reviewer **Date report reviewed**

Appendix D-3, Attachment

Attachment 2, Case Management Report (CMR) Form

In-Home Operations – **CASE MANAGEMENT REPORT (CMR):**	**IHO Region:** ☐ **North** ☐ **South**
Name:	**Date of Visit:**
SSN:	**Case Manager:**

Directions to Home

Home Visit Summary

Purpose of Visit:

Persons Present:

Living Arrangements:

Chart and POT Review:

Staffing Issues:

Medical History:

Review of Home Safety
(please place an X next to the appropriate answers)

In-Home Environment:	☐	**Adequate**	☐	**Not Adequate**
Utilities:	☐	**Working**	☐	**Not Working**
Fire Extinguisher:	☐	**Yes**	☐	**No**
Smoke Detector:	☐	**Yes**	☐	**No**
Pest Problems:	☐	**Yes**	☐	**No**

Home Entrance/Exit:

Emergency Evacuation Plan:

Durable Medical Equipment & Supplies:

Review of Systems: List DME in each system review section, as appropriate

Weight:

Neurological:

Respiratory:

Cardiovascular:

Genito-Urinary:

In-Home Operations –
CASE MANAGEMENT REPORT (CMR):

IHO Region: ☐ **North** ☐ **South**

Name: **Date of Visit:**
SSN: **Case Manager:**

Gastro-Intestinal:

Integumentary:

Musculoskeletal:

Psychosocial:

Review of Other Agencies, Programs, and Services Provided:

Report(s) reviewed: ☐ Yes ☐ No

List report(s) and date: MEDS and IHSS eligibility

Issues/Plan for Resolution

Issues:

➢

Plan for Resolution:

➢

(Please place an X next to the appropriate type(s) of referrals which apply)

Referrals		Date	Referrals		Date	Referrals		Date
Physical Therapy	☐		Enterostomal Therapy	☐		APS	☐	
Occupational Therapy	☐		Medical Social Worker	☐		CPS	☐	
Speech Therapy	☐		AAC Device	☐		L&C	☐	
Other:	☐		Other:	☐				

Comments regarding referrals*: No referrals*

Justification for Program Level of Care and Level of Case Management

Print Name of NEII

Signature of NEII **Date report completed**

Print Name/Title Second Opinion-Reviewer of LOC Determination

Signature of Second Reviewer **Date report reviewed**

Appendix D-3, Attachment

Attachment 3, Instructions for Completing IMS and CMR Forms

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:

IHO Region: ❑ **North** ❑ **South**

Name: **Date of Visit:**
SSN: **Case Manager:** Does not change if visit done by another NE II

Directions to Home

From the office or airport if appropriate, general directions to the beneficiary's home.

Home Visit Summary

Purpose of Visit:
Identify purpose - periodic LOC assessment; reevaluation of LOC due to changes in the beneficiary's condition; other.

Persons Present:
Include only those participating in the visit, the relationship of each participant & the person providing the information.
Identify if additional information obtained from other sources, such as: IHO and/or home chart, observation, etc.

Living Arrangements:
Identify type of dwelling. Identify residents of home & relationship to the beneficiary.
Describe living area for the beneficiary & where the waiver services are provided.

Chart and POT Review:
Review home chart for current POT, recent nurses notes, medication schedule, referral reports (MSW, PT, OT, ST), etc.
Identify if the beneficiary is receiving waiver services as specified on the fully signed POT and per the MOHS by having the beneficiary/family **verbalize** the care and treatments actually being received. Note any differences in the care ordered and actually received.
Identify the POT adequacy based on beneficiary's **assessed** needs – does the POT identify ALL assessed waiver and non-waiver needs? If not, list POT concerns here & reference this section as item #1 in Issues/Plans for Resolution.

Staffing Issues:
If nursing care is provided, list actual frequency of RN Case Manager/supervisory visits, % of staffing coverage & nursing care issues. If unlicensed care is being provided, review availability of provider.

Medical History:
Brief Intake LOC information. Document with each visit justification for LOC. Do not delete previous LOC information.
This is a brief medical history – add only information which is different from past assessments
Example of new info: decannulization 01/01/01; tendon release 01/01/01; NIDDM 01/01/01
MD visits since last home visit - scheduled & unscheduled
Hospitalizations & ER visits over the past year or since last on-site visit - number, length, & reason
Allergies - include drug, food, environmental
Immunizations - optional

Review of Home Safety
(please place an X next to the appropriate answers)

In-Home Environment:	☐	Adequate	☐	Not Adequate
Utilities:	☐	Working	☐	Not Working
Fire Extinguisher:	☐	Yes	☐	No
Smoke Detector:	☐	Yes	☐	No
Pest Problems:	☐	Yes	☐	No

Home Entrance/Exit:
List # of entrances/exits, # that are wheelchair accessible if applicable. Plan for resolution if access not adequate.

Emergency Evacuation Plan:
Evacuation plan posted in chart or home. Family & caregiver aware of plan? Include emergency response system if used.

Durable Medical Equipment & Supplies:

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:

IHO Region: ☐ **North** ☐ **South**

Name: **Date of Visit:**

SSN: **Case Manager:** Does not change if visit done by another NE II

Directions to Home

From the office or airport if appropriate, general directions to the beneficiary's home.

Home Visit Summary

Purpose of Visit:
Identify purpose - periodic LOC assessment; reevaluation of LOC due to changes in the beneficiary's condition; other.

Persons Present:
Include only those participating in the visit, the relationship of each participant & the person providing the information.
Identify if additional information obtained from other sources, such as: IHO and/or home chart, observation, etc.

Living Arrangements:
Identify type of dwelling. Identify residents of home & relationship to the beneficiary.
Describe living area for the beneficiary & where the waiver services are provided.

Chart and POT Review:
Review home chart for current POT, recent nurses notes, medication schedule, referral reports (MSW, PT, OT, ST), etc.
Identify if the beneficiary is receiving waiver services as specified on the fully signed POT and per the MOHS by having the beneficiary/family **verbalize** the care and treatments actually being received. Note any differences in the care ordered and actually received.
Identify the POT adequacy based on beneficiary's **assessed** needs – does the POT identify ALL assessed waiver and non-waiver needs? If not, list POT concerns here & reference this section as item #1 in Issues/Plans for Resolution.

Staffing Issues:
If nursing care is provided, list actual frequency of RN Case Manager/supervisory visits, % of staffing coverage & nursing care issues. If unlicensed care is being provided, review availability of provider.

Medical History:
Brief Intake LOC information. Document with each visit justification for LOC. Do not delete previous LOC information.
This is a brief medical history – add only information which is different from past assessments
Example of new info: decannulization 01/01/01; tendon release 01/01/01; NIDDM 01/01/01
MD visits since last home visit - scheduled & unscheduled
Hospitalizations & ER visits over the past year or since last on-site visit - number, length, & reason
Allergies - include drug, food, environmental
Immunizations - optional

Review of Home Safety
(please place an X next to the appropriate answers)

In-Home Environment:	☐ Adequate	☐ Not Adequate
Utilities:	☐ Working	☐ Not Working
Fire Extinguisher:	☐ Yes	☐ No
Smoke Detector:	☐ Yes	☐ No
Pest Problems:	☐ Yes	☐ No

Home Entrance/Exit:
List # of entrances/exits, # that are wheelchair accessible if applicable. Plan for resolution if access not adequate.

Emergency Evacuation Plan:
Evacuation plan posted in chart or home. Family & caregiver aware of plan? Include emergency response system if used.

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:

IHO Region: ❑ **North** ❑ **South**

Name: **Date of Visit:**
SSN: **Case Manager:** Does not change if visit done by another NE II

Durable Medical Equipment & Supplies:
Name of DME provider and telephone number:
List DME in each system review section, as appropriate
Specify brand, quantities used, & serial numbers if applicable

Review of Systems: List DME in each system review section, as appropriate

Weight:
Amount; date taken
Identify if weight is stable or if there has been any significant and/or noticeable changes since the last visit (gain, loss)

Neurological:
Cognitive level – where information obtained
Developmental age (as determined by regional center, if consumer of a regional center)

Pain management issues; identify location and treatment
Seizure type, frequency, noted activity, date of last seizure; include medications & last prn given if applicable
Vision, hearing or speech issues
Speech Therapy

List devices and supplies, such as AAC devices, vagal nerve stimulator, and availability of information re: use.

Respiratory:
Identify use of supplemental O2 (continuous or PRN); liters of flow; method of delivery (trach, mask, cannula)
Identify use of humidification & frequency of use
Type (oral, nasal, tracheal) and frequency of suctioning, person who cleans & cares for equipment
Frequency of respiratory treatments (scheduled or PRN), date of last PRN & reason
Last URI/pneumonia & treatment

Identify type of artificial ventilation equipment, settings & availability of back-up power
Ventilator status: number of hours on ventilator; ability to sprint off ventilator – length of time
Identify type of tracheostomy & tube size, frequency of trach care, person who changes & date of last change, how the trach cleaning is done (sterile or clean technique) & equipment used

Pulse oximeter use/frequency, # of desaturations in a day or week, interventions; date of last desaturation & intervention
Apnea monitoring, frequency of apneic episodes, date of last episode & intervention
Identify use of specialty equipment such as Phrenic Nerve Pacers, pneumatic belts, staff knowledge of device & availability of information regarding its use

List respiratory supplies and equipment; describe storage of equipment, such as oxygen tanks:

Cardiovascular:
Diagnosis & reason for cardiac medications
Cardiac monitoring
Pacemakers
BP/HR if there are issues
Need for I/O monitoring
Central venous lines, CVL location, frequency of site care, & person responsible for CVL care

List cardiac supplies:

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:

IHO Region: ❑ **North** ❑ **South**

Name: **Date of Visit:**

SSN: **Case Manager:** Does not change if visit done by another NE II

Genito-Urinary:

Incontinent/continent
Indwelling or I&O catheters
Frequency of catheterization, catheter care, drainage bag changes & care
Identify urostomy, kidney problems, dialysis, dysreflexia, & menses
Date of last UTI & treatment

List GU supplies: (ex: adult briefs/diapers)

Gastro-Intestinal:

Nutrition: diet type, route and frequency
Gastric tube: type, size, frequency of care & tube change, who changes tube, date of last change
Gravity flow or pump used? Rate of flow? Residual checks? – If applicable
TPN and/or lipids: route, frequency, rate, person who administers
Incontinent/continent, bowel program, ostomy
Endocrine: treatment, who provides treatment, current issues/problems

List GI supplies:

Integumentary:

Identify all wounds - decubitus, rashes, incisions, stomas
If possible, view decubiti; ask staff present to assess and give you location, size, and stages - **NEII does not assess for staff** Indicate source of verbal and written skin care documentation
Wound sensory assessment (pain assessment), care frequency, enterostomal therapy consults, if applicable
Turning surfaces available if compromised

List special beds, mattresses, or other skin care equipment (ex: special wheelchair pads or cushions).

Musculoskeletal:

Identify disability and functional abilities; ADLs
Identify if restraints are used; frequency and reason
Contractures – upper and/or lower. Mode of mobility
PT and/or OT consults – home treatment plan as applicable with last review/update by therapies
Orthotics and/or prosthetics - frequency and compliance in use

List adaptive equipment & supplies.

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:

IHO Region: ❑ **North** ❑ **South**

Name: **Date of Visit:**
SSN: **Case Manager:** Does not change if visit done by another NE II

Psychosocial:

Ask the following questions to the beneficiary/family/primary caregiver:
Are they coping well with the waiver services as provided?
Are they satisfied with how the care is delivered?
Are the beneficiary's preferences for care considered?
Is the beneficiary receiving all services needed to stay safely in the home – waiver and non-waiver services?
What needs does the beneficiary have now that are not being taken care of?

Does bene/family need a Medical Social Services consult – if so, specify MSW needs
Identify primary caregiver(s) & back-up caregiver(s)
IHSS - # of hours per month; name of IHSS provider & relationship to beneficiary

Identify contingency plans in place to assure back-up care when usual care is not available and the lack of immediate care would pose a threat to health and welfare. (Example: emergencies due to severe weather, flood, fire, etc)
Ask the beneficiary/family if the back-up caregiver plan has ever been used and did it work?

Identify any activities outside the home environment which prevent the beneficiary's seclusion; include:

- PDHC or ADHC – # of hours/days per week spent in day health care
- School - name & type, # of hours/days per week attended; identify whether the home care provider accompanies
- Employment – type, access to medical care provider at work

Ask beneficiary (if applicable) if he/she has concerns with abuse, neglect, or exploitation (of personal property or body)?
Ask beneficiary & caregivers (formal and informal) if they know how to report concerns of abuse, neglect, or exploitation?
Ask beneficiary or family member during the first visit of the year if they received IHO's Client Satisfaction Survey. Was it returned to IHO? If not, explain survey and anonymity of results. Offer to send another one with reminder to return to IHO.

Review of Other Agencies, Programs, and Services Provided:

CCS - (child only); list therapies, treatments, etc. per CCS funds
Regional Center - name of RC, # of hours per month/quarter or service provided; # of parent-vendor hours

Medical transportation:
Non-medical transportation:

Consultation with specialists since last onsite visit, i.e. cardiologist, pulmonologist, neurologists

Report(s) obtained ☐ Yes ☐ No
List report(s) and date:

Issues/Plan for Resolution

Issues:

Identify all issues relating to the care of the beneficiary, including changes in LOC
Identify if previous visit issues were resolved or not.
Identify information located in running record

In-Home Operations –
INTAKE MEDICAL SUMMARY (IMS):
CASE MANAGEMENT REPORT (CMR) INSTRUCTIONS:

IHO Region: ❑ **North** ❑ **South**

Name: **Date of Visit:**

SSN: **Case Manager:** Does not change if visit done by another NE II

Issues/Plan for Resolution:

Identify specific plans for each identified problem/issue & how each will be addressed
Specify each person responsible for the specific part of the resolution plan
Identify that "follow up actions resulting from these issues will be documented in the running record"

(Please place an X next to the appropriate type(s) of referrals which apply)

Referrals		Date	Referrals		Date	Referrals		Date
Physical Therapy	☐	_____	Enterostomal Therapy	☐	_____	APS	☐	_____
Occupational Therapy	☐	_____	Medical Social Worker	☐	_____	CPS	☐	_____
Speech Therapy	☐	_____	AAC Device	☐	_____	L&C	☐	_____
Other:	☐	_____	Other:	☐	_____			_____

Comments regarding referrals:

Justification for Program Level of Care and Level of Case Management

Based upon the information contained in this report, the ( ) facility alternative level of care (LOC) is
(Document recommendations for change in facility alternative LOC with reference to appropriate Title 22 regulations.)

Request for change in Menu of Health Services: ☐ No ☐ Yes: If yes, update menu of services accordingly.
(Identify IHO Case Management level and list justification based on procedure manual.)

Print Name of NEII:

Signature of NEII: **Date report completed:**

Print Name/Title Second Opinion-Reviewer of LOC Determination:

Signature of Second Reviewer: **Date report reviewed:**

Appendix D-3, Attachment

Attachment 4, Case Management Acuity Systems

Case Management Acuity System

Levels of Case Management

Level I

- No recent unscheduled hospitalization.
- Caregiver/Beneficiary compliant with Plan of Treatment.
- Home adequate to provide the care.
- Adequate staffing.
- No eligibility issues.
- The Provider functions independently, rarely calls In-Home Operations with issues for problems and calls In-Home Operations with a plan in place to resolve issues.

Level II

- Staffing Issues: Provider providing less than 85–90% staffing.
- Eligibility issues.
- Utility problems/phone/garbage pick up/electricity.
- Family relocates.
- Durable Medical Equipment/Supply issues.

Level III

- Change in State Plan and/or Waiver services more than twice per year (hours, services, Menu of Home and Community-Based Services Waiver Services adjustments, may include Notice of Action).
- Provider rarely submits Plan of Treatment with the Treatment Authorization Request.
- Provider needs guidance/Treatment Authorization Request/Plan of Treatment/Case management.
- Caregiver unavailable 50% of the time/is non compliant.
- Beneficiary non-compliant with the home program 50% of the time.
- Inappropriate/unsafe space for Beneficiary, Provider, and/or equipment/supplies.
- Providers' inability to access the home/structure/environment.
- Eviction.
- Beneficiary hospitalized more than 4 times a year for unscheduled visits.
- Frequent emergency Room Visits (one or more per month).
- Stage II or higher decubiti/wound.

Case Management Acuity System (cont.)

- Tracheostomized and ventilator-dependent with respiratory complications.
- Central Line/Venus Access: Total Parenteral Nutrition/Lipids/Antibiotic administrations in the home.
- Chest tubes.
- Chronic infection process/respiratory/skin/urinary (3 or more per year).
- Provider does not complete enrollment process timely resulting in delay of authorization of services.
- Provider frequently submits inaccurate claims/timesheets.
- Cases that have Home and Community-Based Services Personal Care Benefit.
- Cases that have Home and Community-Based Services Registered and/or Licensed Vocational Nurses.
- Multiple changes of Providers (3 or more per year).

Level IV

- The Provider rarely provides case management with follow up.
- The Provider rarely communicates with In-Home Operations for unresolved issues.
- Involvement with Board of Registered Nursing, Board of Vocational Nursing and Psychiatric Technicians, Department of Health Services; Licensing and Certification and/or Audits and Investigations.
- Substance abuse in the home/suspected/documented.
- Domestic violence.
- Involvement with Child or Adult Protective Services.
- Pest problems/uncontrolled.
- Beneficiary hospitalized for more than 30 days at a time.
- Phrenic Nerve Pacemaker.
- Potential for Fair Hearing.
- Provider requires more than two visits per year to resolve issues.
- Critical health and safety issues.

Case Management Acuity System (cont.)

Components for Case Management Levels

The following components are used to define the four levels of complexity/involvement for In-Home Cases (Note: providers are: Home Health Agencies, Home and Community-Based Service Waiver Registered Nurses, Home and Community-Based Benefit Providers, Professional Corporations).

Provider Issues:

- Staffing issues: Provider providing less than 85%-90% staffing.
- Functions independently, rarely submits Plan of Treatment with Treatment Authorization Request for authorization of services.
- The Provider rarely provides case management with follow up.
- The Provider rarely communicates unresolved issues with In-Home Operations.
- Involvement with Board of Registered Nursing, Board of Vocational Nursing and Psychiatric Technicians, Department of Health Services; Licensing and Certification and/or Audits and Investigations.
- Provider requires more than two visits per year to resolve issues.
- Provider does not complete enrollment process timely resulting in delay in authorization of services.
- Provider frequently submits inaccurate claims/timesheets.
- Cases that have Home and Community-Based Services Personal Care Benefit.
- Cases that have Home and Community-Based Services Registered Nurse and Licensed Vocational Nurse.
- Multiple changes of Providers (3 or more per year).

Psychosocial Issues:

- Caregiver is non-compliant and unavailable 50% of the time.
- Beneficiary non-compliant with home program 50% of the time.
- Substance abuse in the home/suspected/documented.
- Domestic violence.
- Involvement with Child or Adult Protective Services.
- Eligibility issues.
- Fair Hearing issues.

Case Management Acuity System (cont.)

Inadequate Home:

- Inappropriate/unsafe space for beneficiary, nurse, and/or equipment.
- Uncontrolled pest problems.
- Provider inability to access the home/structure/environmental.
- Utility problems/phone/garbage pick up/electricity.
- Eviction.
- Family relocates.
- Durable Medical Equipment/Supply issues.
- Critical health and safety issues.

Hospitalization:

- Beneficiary hospitalized more than 30 days at a time.
- Beneficiary hospitalized more than 4 times a year for unscheduled visits.
- Frequent Emergency Room visits (more than one per month).

Case Profile Increasing Acuity:

- Stage II or higher decubiti/wound.
- Trach/Vent with respiratory complications.
- Phrenic Nerve Pacemaker.
- Central Line Total Parenteral Nutrition/Lipids/Antibiotics administration in the home.
- Chest Tubes.
- Chronic infection process/respiratory/skin/urinary - three or more a year.

Case Management Visits:

- Annual Provider visits:
- Visits for Nursing Facility A/B, Nursing Facility Subacute, and In-Home Medical Care waiver every 6 months.

Appendix D-3, Attachment

Attachment 5, Home Safety Evaluation (Form and Instructions)

MEDI-CAL IN-HOME OPERATIONS
HOME AND COMMUNITY-BASED SERVICES
HOME SAFETY EVALUATION

1. **Beneficiary:**				2. **Date**:
3. **HCBS Provider:**				
4. **Address:**				5. **Initial Evaluation:** ☐ **Yes** ☐ **No**
				6. **Date of Previous Evaluation:**
7. **Telephone #:**				
8. **Primary Care Giver:**				
9. **Relationship to beneficiary**:				**Comments:**
10. House ☐ Apartment ☐ Other ☐	**Yes**	**No**	**N/A**	11.
12. Beneficiary owned				
13. Family member owns				
14. Rented				
Structural Barriers:				
15. Exterior stairs: Front ☐ Rear ☐				16. Number of steps_____
17. Accessible to beneficiary				
18. Interior stairs				19. Number of steps_____
20. Accessible to beneficiary				
21. Ramp				22. Location:
23. Doorways adequate for beneficiary/wheelchair				
24. Hallways adequate for beneficiary/wheelchair				
25. Carpets are secure				
Utilities:				
26. Electricity functioning				
27. Electrical cords intact				
28. Electrical outlets secure				
29. Lighting adequate in beneficiary care areas				
30. Gas functioning				
31. Adequate temperature control for beneficiary				

MEDI-CAL IN-HOME OPERATIONS
HOME AND COMMUNITY-BASED SERVICES
HOME SAFETY EVALUATION

32. Functioning telephone in beneficiary care area				
33 Smoke alarms functional				
34. Fire extinguisher is accessible				35. Location:
36. Adequate refrigeration for medicines				
	Yes	**No**	**N/A**	**Comments:**
Bathroom:				
37. Beneficiary can access bathroom				
38. Hot and cold running water				
39. Grab bars are present for patient use				
Evacuation Plan:				
40. Family verbalizes emergency evacuation plan				
Medical Gases:				
41. Oxygen/medical gas tanks are safely stored				
42. Signs posted indicating oxygen is in use				
Infestations				
43. Flying insects present/described by client				
44. Crawling insects present/described by client				
45. Rodent or other mammal infestations				
Summary:				
46. Home is Adequate for the Delivery of Home and Community-Based Services.				

47. **Signature of person completing document:**	48. **Date:**
49. **Signature of beneficiary/representative:**	50. **Date:**
51. **Use other side of document to diagram Emergency Evacuation Plan.**	

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

MEDI-CAL IN-HOME OPERATIONS
HOME AND COMMUNITY-BASED SERVICES (HCBS)
HOME SAFETY EVALUATION INSTRUCTION FORM

This document is an Excel-based form that can be completed either electronically or manually. The **Comments** section may be used throughout the document to provide explanatory information as necessary. Please complete the form as follows:

General Information:

Box 1: Name of beneficiary
Box 2: Today's date
Box 3: Name of HCBS provider – this may be a Home Health Agency, HCBS Waiver RN, or other individual in the role of Waiver Personal Care Service Provider
Box 4: Address of the beneficiary
Box 5: "Yes" or "No" to indicate whether or not this the first evaluation of this beneficiary
Box 6: If there is a previous evaluation, indicate the date of the evaluation
Box 7: Enter beneficiary's phone number
Box 8: Identifies the individual who is responsible for the beneficiary
Box 9: Identifies the relationship between the primary care giver and the beneficiary

Residence:

Box 10: Check the appropriate box to indicate the nature of the residence: house or apartment.
Box 11: (If "Other" to 10) specify under Comments,
Box 12-14: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question

Structural Barriers:

Box 15: Indicate if there are stairs outside of the home, front access or rear access
Box 16: (If "Yes" to 15) indicate the number of stairs outside the home; indicate front and/or rear
Box 17: Accessible means the beneficiary is able to walk up and down the steps without assistance
Box 18: Indicate if there are stairs within the home
Box 19: (If "Yes" to 18) indicate the number of stairs within the home

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(916) 552-9271
Internet Address: www.dhs.ca.gov

Instructions for Page 2 of the Medi-Cal In-Home Operations Home and Community-Based Services Home Safety Evaluation Instruction Form:

Box 20: Accessible means is the beneficiary is able to walk up and down the steps without assistance
Box 21: Indicate if a ramp exists to facilitate wheelchair access
Box 22: (If "Yes" to 21) identify the location of the ramp
Box 23-25: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question

Utilities:
Box 26-34: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question
Box 35: Identify the room and location of the fire extinguisher
Box 36: Indicate if there is adequate refrigeration capability for medicines as needed

Bathroom:
Box 37: Indicate if the beneficiary is able to access the bathroom with or without adaptive equipment
Box 38-39: Check the appropriate box to indicate "Yes", "No" or "N/A" for each question

Evacuation Plan:
Box 40: Check the appropriate box to indicate "Yes", "No", or "N/A"

Medical Gases:
Box 41: Check the appropriate box to indicate "Yes", "No", or "N/A"
Box 42: (If yes to 41) check the appropriate box to indicate "Yes" or "No" and indicate the location of the signs under the comments section.

Infestations:
Box 43-45: Check the appropriate box to indicate "Yes", "No", or "N/A" for each question. If yes to these boxes, provide explanation under comments.

Summary:
Box 46: The summary statement reflects whether or not, in your judgment, the home is safe and adequate for the delivery of the proposed services under the Home- and Community-Based Services waiver.

Signatures:
Box 47: Signature of the individual who fills out the document
Box 48: Date of the document completion
Box 49: Signature of the beneficiary or the person who signs for the beneficiary
Box 50: Date of the signing of the document

Emergency Evacuation Plan:
Box 51: The reverse side of this document is available to sketch the outline of the floor plan of the residence and to indicate the proposed emergency evacuation routes as indicated in Box 40.
Or, you may attach a copy of the emergency plan to this document.

Appendix D-3, Attachment

Attachment 6, Menu of Home and Community-Based Waiver Services (MOHS) Forms

Department of Health Services
In-Home Operations
Menu Of Health Services

Name:		NE II:	
SSN:		MOHS Date:	
DOB:		Waiver SOS:	
G Factor (Annual)		Waiver:	
		Level of Care and Annual Program Cost:	

Beneficiary Cost Neutrality	
Daily	$0.00
Annual	$0.00

If the Cost Neutrality figures are in (-), then the program is not cost neutral.

Summary of Services

Direct Care Services	Daily	Week	Month (30 days)
IHSS			0.00
Waiver Services			
R.N. (PDN)	0.00	0.00	0.00
LVN (PDN)	0.00	0.00	0.00
CHHA	0.00	0.00	0.00
WPCS	0.00	0.00	0.00
State Plan Services			
EPSDT R.N.	0.00	0.00	0.00
EPSDT LVN	0.00	0.00	0.00
EPSDT CHHA	0.00	0.00	0.00
EPSDT PDHC	0.00	0.00	0.00
Total hours:	0.00	0.00	0.00
	(24 max)	(168 max)	(720 max)

Other Waiver/State Plan Services:

Comment: IHSS/WPC services are calculated on a 30-day month. The daily hours will vary based upon the number of days per month. They cannot exceed the maximum monthly total authorized.
The above direct care services do not include: ADHC, Private Insurance funded PDN, Respite or CHLF-A. If the beneficiary is receiving any of these services see the additional comment section below.

Additional Comments:

Cost Neutrality

Name:
SSN:
DOB:

NE II:
MOHS Date:
Waiver SOS:
Waiver:
Level of Care and
Annual Program Cost:

G factor (Annual)	$	-
G Factor (Daily)	$	-
G factor (90 Days)	$	-
G factor (180 Days)	$	-
Daily Waiver Costs (D)	$	-
30 Day Waiver Costs (D)	$	-
90 Day Waiver Costs (D)	$	-
180 Day Waiver Costs (D)	$	-
Annual Waiver Costs (D)	$	-
Daily State Plan Costs (D')	$	-
30 Day State Plan Costs (D')	$	-
90 Day State Plan Costs (D')	$	-
180 Day State Plan Costs (D')	$	-
Annual State Plan Costs (D')	$	-
Daily D + D' Costs	$	-
90 Day D + D' Costs	$	-
180 Day D + D' Costs	$	-
Annual D + D' Costs	$	-
Overall Cost Neutrality (Daily)		
Overall Cost Neutrality (Annual)		

Beneficiary Cost Neutrality

Daily

Annual

If the Cost Neutrality figures are in (-), then the program is not cost neutral.

Advance Pay = No PCP = Yes

Month = 30 days = 720 hours 24 hours/day = 720 hours/month

IHSS PCS provided through IHSS Individual Providers		For IHSS PCS provided through an agency or a contract vendor	
Authorized IHSS PCS hrs/mo		Authorized IHSS PCS hrs/mo	
IHSS SOC/mo		IHSS SOC/mo	
Hourly rate		Hourly rate	
Protective Supervision hrs/mo		Protective Supervision hrs/mo	
(enter number exactly as it appears on the RELC screen line WW purchase column)		(enter number exactly as it appears on the RELC screen line WW purchase column)	
IHSS PCS hrs/mo		IHSS PCS hrs/mo	
IHSS PCS hrs/day		IHSS PCS hrs/day	
Hourly rate (Federal and State contributions)	$ -	Hourly rate (Federal and State contributions)	$ -
Daily IHSS PCS State Plan Cost	$ -	Daily IHSS PCS	$ -
Annual IHSS PCS State Plan Cost	$ -	Annual IHSS PCS State Plan Cost	$ -

State Plan Costs (FACTOR D')

Name: **NE II:**
SSN: **MOHS Date:**
DOB:

State Plan Costs:	Unit Cost	# of units in 90 Days	Daily	Annual
EPSDT Nursing Services **(Complete EPSDT Worksheet)**			$ -	$ -
Adult Day Health Care (daily)	$ 69.58		$ -	$ -
Pediatric Day Health Care (hourly)	$ 29.41		$ -	$ -
PCS under IHSS (incl. taxes) **(Complete IHSS PCS Worksheet)**	$ -		$ -	$ -
PCS under IHSS provided through an agency or a contract vendor with the county	$ -		$ -	$ -
Oxygen, Gas	$ 4.33		$ -	$ -
Oxygen, Liquid	$ 9.91		$ -	$ -
Oxygen, Concentrator (rental)	$ 183.04		$ -	$ -
Ventilator (rental)	$ 649.07		$ -	$ -
Transportation				
Response to Call	$ -		$ -	$ -
Mileage	$ 1.30		$ -	$ -
Gloves, Disposable	$ -		$ -	$ -
Incontinent Supplies	$ -		$ -	$ -
Family Therapy	$ -		$ -	$ -
DME/Supply (<u>one time</u> purchases)				
Anti-Decubitus Supplies	$ -		$ -	$ -
Bed (purchase)	$ -		$ -	$ -
Nebulizer (purchase)	$ 189.41		$ -	$ -
Suction Equipment, Portable	$ 439.58		$ -	$ -
Suction Equipment, Stationary	$ 439.58		$ -	$ -
Walkers	$ -		$ -	$ -
Wheelchair, Custom	$ -		$ -	$ -
Wheelchair, Manual	$ -		$ -	$ -
	Subtotal		$ -	$ -
DME/Supply (<u>ongoing</u> purchases)				
	$ -		$ -	$ -
DME Rental				
	$ -		$ -	$ -
<u>Home Health Agency</u>				
Skilled Nursing Care Services	$ 74.86		$ -	$ -
MSW	$ 96.22		$ -	$ -
Physical Therapy	$ 68.84		$ -	$ -
Occupational Therapy	$ 71.36		$ -	$ -
Speech Therapy	$ 78.43		$ -	$ -
Other:				
	$ -		$ -	$ -
State Program Costs (FACTOR D')	**Total**			

Waiver Program Costs (Factor D)

Name: **NE II:**
SSN: **MOHS Date:**
DOB:

Waiver Program Costs:	Unit Cost	# of units in 90 Days	Daily	Annual
Case Management:				
Home Health Agency	$ 45.43		$ -	$ -
Individual Nurse Provider	$ 35.77		$ -	$ -
Individual Licensed Profesional	$ 35.77		$ -	$ -
Professional Organization	$ 45.43		$ -	$ -
Service Coordination:				
Home Health Agency	$ 35.77		$ -	$ -
Individual Nurse Provider	$ 35.77		$ -	$ -
Individual Nurse Profesional	$ 35.77		$ -	$ -
Professional Organization	$ 35.77		$ -	$ -
Personal Care Services (PCS):				
Home Health Agency	$ -		$ -	$ -
Service Agency	$ -		$ -	$ -
Individual Provider	$ -		$ -	$ -
(Month = 30 days = 720 hours)				
Private Duty Nursing:				
INP - R.N.	$ 31.94		$ -	$ -
INP - R.N. - Shared	$ 35.13		$ -	$ -
INP - R.N. - Supervision	$ 35.77		$ -	$ -
INP - LVN	$ 24.42		$ -	$ -
INP - LVN - Shared	$ 26.86		$ -	$ -
HHA - R.N.	$ 40.57		$ -	$ -
HHA - R.N. - Shared	$ 44.63		$ -	$ -
HHA - LVN	$ 29.41		$ -	$ -
HHA - LVN - Shared	$ 32.35		$ -	$ -
CLHF - Type A	$ -		$ -	$ -
CHHA:				
HHA - CHHA	$ 18.90		$ -	$ -
HHA - CHHA - Shared	$ 20.79		$ -	$ -
Respite:				
INP - R.N.	$ 31.94		$ -	$ -
INP - R.N. - Shared	$ 35.13		$ -	$ -
INP - R.N. - Supervision	$ 35.77		$ -	$ -
INP - LVN	$ 24.42		$ -	$ -
INP - LVN - Shared	$ 26.86		$ -	$ -
Home Health Agency - PCS	$ -		$ -	$ -
Individual Provider - PCS	$ -		$ -	$ -
HHA - R.N.	$ 40.57		$ -	$ -
HHA - R.N. - Shared	$ 44.63		$ -	$ -
HHA - LVN	$ 29.41		$ -	$ -
HHA - LVN - Shared	$ 32.35		$ -	$ -
HHA - CHHA	$ 18.90		$ -	$ -
HHA - CHHA - Shared	$ 20.79		$ -	$ -
Skilled Nursing Facility	$ -		****Enter	****Enter
Environmental Accessibity Adaptations: **(One time w/$5000 lifetime cap)**	$ -		$ -	$ -
Personal Emergency Response Systems:	$ -		$ -	$ -
Family Training:				
HHA - R.N.	$ 45.43		$ -	$ -
INP - R.N.	$ 35.77		$ -	$ -
Utility Coverage (Average Cost):				
Home Health Agency	$ -		$ -	$ -
Individual Nurse Provider	$ -		$ -	$ -
Professional Organization	$ -		$ -	$ -
Waiver Program Costs (FACTOR D)	**Total**		**$ -**	**$ -**

Waiver Program Costs (Factor D)

Name: **NE II:**
SSN: **MOHS Date:**
DOB:

Waiver Program Costs:	Unit Cost	# of units in 90 Days	Daily	Annual
Case Management:				
Home Health Agency	$ 45.43		$ -	$ -
Individual Nurse Provider	$ 35.77		$ -	$ -
Individual Licensed Profesional	$ 35.77		$ -	$ -
Professional Organization	$ 45.43		$ -	$ -
Service Coordination:				
Home Health Agency	$ 35.77		$ -	$ -
Individual Nurse Provider	$ 35.77		$ -	$ -
Individual Nurse Profesional	$ 35.77		$ -	$ -
Professional Organization	$ 35.77		$ -	$ -
Personal Care Services (PCS):				
Home Health Agency	$ -		$ -	$ -
Service Agency	$ -		$ -	$ -
Individual Provider	$ -		$ -	$ -
(Month = 30 days = 720 hours)				
Private Duty Nursing:				
INP - R.N.	$ 31.94		$ -	$ -
INP - R.N. - Shared	$ 35.13		$ -	$ -
INP - R.N. - Supervision	$ 35.77		$ -	$ -
INP - LVN	$ 24.42		$ -	$ -
INP - LVN - Shared	$ 26.86		$ -	$ -
HHA - R.N.	$ 40.57		$ -	$ -
HHA - R.N. - Shared	$ 44.63		$ -	$ -
HHA - LVN	$ 29.41		$ -	$ -
HHA - LVN - Shared	$ 32.35		$ -	$ -
CLHF - Type A	$ -		$ -	$ -
CHHA:				
HHA - CHHA	$ 18.90		$ -	$ -
HHA - CHHA - Shared	$ 20.79		$ -	$ -
Respite:				
INP - R.N.	$ 31.94		$ -	$ -
INP - R.N. - Shared	$ 35.13		$ -	$ -
INP - R.N. - Supervision	$ 35.77		$ -	$ -
INP - LVN	$ 24.42		$ -	$ -
INP - LVN - Shared	$ 26.86		$ -	$ -
Home Health Agency - PCS	$ -		$ -	$ -
Individual Provider - PCS	$ -		$ -	$ -
HHA - R.N.	$ 40.57		$ -	$ -
HHA - R.N. - Shared	$ 44.63		$ -	$ -
HHA - LVN	$ 29.41		$ -	$ -
HHA - LVN - Shared	$ 32.35		$ -	$ -
HHA - CHHA	$ 18.90		$ -	$ -
HHA - CHHA - Shared	$ 20.79		$ -	$ -
Skilled Nursing Facility	$ -		****Enter	****Enter
Environmental Accessibity Adaptations: **(One time w/$5000 lifetime cap)**	$ -		$ -	$ -
Personal Emergency Response Systems:	$ -		$ -	$ -
Family Training:				
HHA - R.N.	$ 45.43		$ -	$ -
INP - R.N.	$ 35.77		$ -	$ -
Utility Coverage (Average Cost):				
Home Health Agency	$ -		$ -	$ -
Individual Nurse Provider	$ -		$ -	$ -
Professional Organization	$ -		$ -	$ -
Waiver Program Costs (FACTOR D)	**Total**		**$ -**	**$ -**

Appendix D-4, Freedom of Choice and Fair Hearing

a. Freedom of Choice and Fair Hearing

1. When an individual is determined to likely require a level of care indicated in item 2 of this request, for a period of at least 180 consecutive days, the individual or his/her legal representative will be:

   i. Informed of any feasible alternatives under the waiver.

   ii. Given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice or the provider(s) of their choice.

3. The following are attached to this Appendix:

   i. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   ii. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   iii. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   iv. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. Freedom of Choice Documentation

Specify where copies of this form are maintained:

A beneficiary or, if appropriate, their representative shall evidence the choice to receive home and community-based services by signing a HCBS “Freedom of Choice” form. Completed forms will be retained in the beneficiary's records at the designated Medi-Cal office.

Appendix D-4, Attachments

Procedures for Freedom of Choice

The procedures for informing the eligible recipients of the feasible alternatives available under the waiver, and allowing recipients to choose either institutional or home and community-based services, consists of provision of verbal information to the beneficiary or, if appropriate, the authorized representative prior to obtaining their signature on the HCBS Freedom of Choice form.

Procedures for Fair Hearing

The procedures for informing an eligible recipient or their authorized representative of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E, are pre-printed on the Notice of Action form which is used to notify the beneficiary or his/her representative when a request for a HCBS service is not approved as requested or denied. The Notice of Action document for the initial request is called the Jackson v. Rank (JvR) form. When HCBS waiver services have been previously authorized and are now reduced or terminated by DHS, a Notice of Action form will be forwarded to the beneficiary. This Notice of Action document is called the Frank v. Kiser (FvK) form.

Appendix D-4, Forms

Attachment 7, Freedom of Choice Document and Informing Notice

Attachment 8, Informing Notice

Attachment 9, Notice of Action and/or Request for Fair Hearing

Attachment 7, Freedom of Choice Document

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

MEDI-CAL HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVER FREEDOM OF CHOICE LETTER

Date

Beneficiary Name
Address1
Address2

Dear:

The Department of Health Services, Medi-Cal In-Home Operations (IHO) has received a request for HCBS waiver services for {**Beneficiary Name}** under the In-Home Medical Care (IHMC) Waiver.

HCBS waiver services are designed specifically for Medi-Cal beneficiaries to assist them in remaining in their homes as an alternative to care in a licensed health care facility, also known as an "***institutional alternative***". Whether accepting or declining these services, IHO is required to obtain written confirmation of your choice.

The acceptance or refusal of IHMC Waiver services is based on the following:

1. You or your authorized representative have been informed of the services available to you under the IHMC Waiver to be provided to you as an alternative to care in a licensed heath care facility.
2. You have the right to choose an HCBS waiver service provider who has been identified under the waiver as an able provider of the service(s) requested.
3. You are aware of the roles and responsibilities of all of the individuals who are involved in your home care program, including your own.

After you have signed and dated the enclosed Freedom of Choice Document, please return it to IHO in the self-addressed envelope provided for you within five days of receipt of this letter. Postage ***is not*** included, so please make sure you affix the proper postage amount. This document will be kept in your files at the designated IHO office. It is suggested that you make a copy for yourself prior to returning this document to IHO.

Enclosures

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(916) 552-9271
Internet Address: www.dhs.ca.gov

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date

MEDI-CAL HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVER FREEDOM OF CHOICE DOCUMENT

If you **agree** to accept the HCBS waiver services in your home as an alternative to care in a licensed health care facility, please check the "**Accept**" box below, print your name, date the form, and sign your name. If you are unable to sign the form, the individual responsible for you should then complete the form as indicated.

☐ **Accept In-Home Medical Care Waiver**

Printed Name of Beneficiary/Responsible Person _____ Date Signed _____

Relationship to Beneficiary _____

Signature _____

If you **do not agree** to accept the HCBS waiver services in your home and have chosen to be in a licensed health care facility or have other alternatives available to you, please check the "**Decline**" box below, print your name, date the form, and sign your name. If you are unable to sign the form, the individual responsible for you should then complete the form as indicated.

☐ **Decline In-Home Medical Care Waiver**

Printed Name of Beneficiary/Responsible Person _____ Date Signed _____

Relationship to Beneficiary _____

Signature _____

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(916) 552-9271
Internet Address: www.dhs.ca.gov

Attachment 8, Informing Notice (sent to Beneficiary, legally responsible persons, physician, and waiver providers)

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date
Name
Address
Address

Dear:

MEDI-CAL HOME- AND COMMUNITY-BASED SERVICES (HCBS)
WAIVER INFORMING NOTICE FOR (Beneficiary)

The Department of Health Services' (the Department's), Medi-Cal In-Home Operations (IHO) has received a request for HCBS Waiver services for (Beneficiary) under the In-Home Medical Care (IHMC) Waiver.

The purpose of this HCBS Informing Notice is to describe the waiver program and to outline the roles and responsibilities of the beneficiary and primary caregiver, the primary care physician, the HCBS Waiver service provider(s), and IHO. Ultimately, our goal is to inform all interested individuals regarding what is needed from them in order to ensure the successful development and implementation of a safe home program under the IHMC Waiver.

The HCBS Waivers are sets of services designed for Medi-Cal beneficiaries to assist them in remaining in their homes as an alternative to care in a licensed health care facility, also known as the "***institutional alternative***". In order for IHO to authorize these services, there must be a medical need for the services. Additionally, the cost of the requested service(s) shall not exceed the costs Medi-Cal would have paid to the health care facility alternative should the service(s) not have been provided in the home setting. The licensed health care facility alternative is determined by IHO and is based upon criteria outlined in regulations, as well as in the requested waiver program. The services available under the IHMC Waiver include case management, private duty nursing, and respite.

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(916) 552-9271
Internet Address: www.dhs.ca.gov

State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date
Address
Dear :

MEDI-CAL HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVER
INFORMING NOTICE FOR (Beneficiary)

The Department of Health Services' (the Department's), Medi-Cal In-Home Operations (IHO) has received a request for HCBS waiver services for (Beneficiary) under the In-Home Medical Care (IHMC) Waiver.

The purpose of this HCBS Informing Notice is to describe the waiver program and to outline the roles and responsibilities of the beneficiary and primary caregiver, the primary care physician, the HCBS waiver service provider(s), and IHO. Ultimately, our goal is to inform all interested individuals regarding what is needed from them in order to ensure the successful development and implementation of a safe home program under the IHMC Waiver.

The HCBS waivers are sets of services designed for Medi-Cal beneficiaries to assist them in remaining in their homes as an alternative to care in a licensed health care facility, also known as the "***institutional alternative***". In order for IHO to authorize these services, there must be a medical need for the services. Additionally, the cost of the requested service(s) shall not exceed the costs Medi-Cal would have paid to the health care facility alternative should the service(s) not have been provided in the home setting. The licensed health care facility alternative is determined by IHO and is based upon criteria outlined in regulations, as well as in the requested waiver program. The services available under the IHMC Waiver include case management, private duty nursing, and respite.

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(916) 552-9271
Internet Address: www.dhs.ca.gov

State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date
Provider
Address
Address

Dear:

MEDI-CAL HOME- AND COMMUNITY-BASED SERVICES (HCBS) WAIVER
INFORMING NOTICE FOR (Beneficiary)

The Department of Health Services' (the Department's), Medi-Cal In-Home Operations (IHO) has received a request for HCBS waiver services for (Beneficiary) under the In-Home Medical Care (IHMC) Waiver.

The purpose of this HCBS Informing Notice is to describe the waiver program and to outline the roles and responsibilities of the beneficiary and primary caregiver, the primary care physician, the HCBS waiver service provider(s), and IHO. Ultimately, our goal is to inform all interested individuals regarding what is needed from them in order to ensure the successful development and implementation of a safe home program under the IHMC Waiver.

The HCBS waivers are sets of services designed for Medi-Cal beneficiaries to assist them in remaining in their homes as an alternative to care in a licensed health care facility, also known as the "***institutional alternative***". In order for IHO to authorize these services, there must be a medical need for the services. Additionally, the cost of the requested service(s) shall not exceed the costs Medi-Cal would have paid to the health care facility alternative should the service(s) not have been provided in the home setting. The licensed health care facility alternative is determined by IHO and is based upon criteria outlined in regulations, as well as in the requested waiver program. The services available under the IHMC Waiver include case management, private duty nursing, and respite.

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(916) 552-9271
Internet Address: www.dhs.ca.gov

(Beneficiary)
Page
Date

In order for IHO to authorize initial or ongoing IHMC Waiver services, the following information is needed:

1. A Treatment Authorization Request (TAR), which is the primary way to request HCBS waiver services. TARs are submitted to IHO by the selected HCBS primary waiver service provider. This formal request may also be submitted in a different written format, as required by IHO, when the HCBS primary provider is an unlicensed individual or a nontraditional Medi-Cal provider;

2. A plan of treatment (POT), which is the physician's order for the HCBS waiver services. The POT outlines the needs of the beneficiary and must include all waiver and non-waiver services needed by the individual in order to be maintained safely in the home setting. This would include services provided by the identified HCBS waiver service provider and any other provider type; and,

3. Medical justification for the HCBS waiver services. This information should support the medical need for the services and assist IHO in determining the appropriate health care facility alternative.

NOTE: Initial and ongoing requests for HCBS waiver services must demonstrate a medical need for the services and be cost-effective in order to be authorized or reauthorized. Changes in medical needs may impact the future level of care and amount of services that may be authorized by IHO. Should IHO determine a change in the authorization of services is necessary, the beneficiary will be notified in writing about the change and why it was made. This notification will include appeal rights for the beneficiary, as required by law.

ROLES AND RESPONSIBILITIES FOR:

1. The Beneficiary and Primary Caregivers

- The beneficiary must identify a support network system, such as a primary caregiver, to support him or her in the event the HCBS waiver service provider is not able to provide the total number of authorized services.

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- The beneficiary must be Medi-Cal eligible with no restrictions on the amount of services he or she is eligible to receive. The physician must document that the beneficiary has medical needs that can be safely provided for in the home.

- A home must be maintained that ensures the health and safety of the beneficiary, as well as the HCBS waiver services provider(s). This would include: an area to accommodate the medical equipment and supplies, an appropriate area for cleaning the supplies, adequate lighting and temperature control, an area free from pest infestations, working utilities, a functional telephone, an adequate entrance into the home, and an emergency plan in the event of a home evacuation.

- The beneficiary and/or primary caregiver must assist the HCBS waiver service provider(s) and the primary care physician in the development of the POT that outlines the home program and the needs of the individual.

- The beneficiary and/or the primary caregiver must comply with the developed POT in order to ensure a successful home program.

- The beneficiary and/or the primary caregiver must work cooperatively with IHO in identifying services to assist in maintaining the individual in the home. This would include needed services from the IHMC Waiver within program cost limits, Medi-Cal, and other community or government funded programs.

- The beneficiary and/or the primary caregiver must participate actively in the home care program. For the primary caregiver, this would include being trained in the care needs of the beneficiary, being present in the event the HCBS waiver service provider is not available, and following any additional physician's orders, if applicable, to ensure the health, safety, and welfare of the beneficiary.

- The beneficiary and/or the primary caregiver must contact the HCBS waiver service provider(s) or the IHO nurse case manager regarding any issues or concerns with the home program that may impact the delivery of services.

- The beneficiary and/or the primary caregiver must contact the HCBS waiver services provider(s) and IHO as soon as possible, in the event there are changes with the availability of the primary caregiver. This notification is necessary in the event the changes in the availability of the caregiver impact the safety, health, and welfare of the beneficiary.

(Beneficiary)
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Date

- The beneficiary and/or the primary caregiver must notify the HCBS waiver service provider(s) and IHO as soon as possible when changing residences. This is necessary so that IHO can assist as needed in linking the beneficiary with other potential providers of services in the new community. The IHO nurse case manager may also request a home visit of the new residence for evaluation of health and safety, as appropriate.

- The beneficiary and/or the primary caregiver must seek out a new HCBS waiver service provider in the event the current HCBS waiver service provider is not able to meet the needs of the beneficiary. Depending upon the availability of a new HCBS waiver service provider, there may be a waiting period of 30 days or more before the change is effective. The beneficiary may contact the IHO nurse case manager for assistance in locating a new HCBS waiver service provider.

2. The Primary Care Physician must:

- Provide the following information to the HCBS waiver service provider in a timely manner: written beneficiary-specific orders, a complete and accurate written medical record that includes current medical diagnoses, a history and physical assessment with a systems review, and other medical documentation as requested.

- Participate actively with the beneficiary and the HCBS waiver service provider in developing and/or writing a POT that is individualized for the needs of the beneficiary, and includes all needed services under the IHMC Waiver, Medi-Cal, and other services provided by public or private programs.

- Actively assist the HCBS waiver service provider and the beneficiary with any needed revisions to the POT.

- Provide written documentation that the beneficiary's medical condition is stable and that the provision of services under the IHMC Waiver can be provided safely in the home.

- Provide written documentation that the medical needs of the beneficiary are of such a nature that the beneficiary would require care in a licensed health care facility, if the beneficiary cannot be safely maintained in the home.

(Beneficiary)
Page
Date

- Work cooperatively with the HCBS waiver service provider and IHO in providing updated medical information as requested to substantiate both initial and ongoing medical necessity for the services requested.

- Accept full responsibility for providing and coordinating the beneficiary's medical needs for the home care program, as documented in a written statement to be provided in a format satisfactory to IHO.

3. The HCBS Waiver Services Provider must:

- Sign and have on file with IHO an HCBS Waiver Provider Agreement. This agreement must be signed, dated, and returned to IHO before HCBS waiver services can be authorized.

- Assess for the availability of a support network system for the beneficiary with the onset of services and periodically thereafter and no less than twice a year. In the event the beneficiary does not have this support network system or if changes are needed the HCBS provider of services will assist the beneficiary in developing and/or maintaining this system.

- Be licensed and/or certified and appropriately trained as outlined in the IHMC Waiver. The provider may be a current Medi-Cal provider or a provider under the HCBS waiver. In the event the provider is identified to provide only HCBS waiver services, the provider must meet all applicable Medi-Cal criteria. The HCBS waiver service provider must maintain compliance with all applicable state and federal requirements, including but not limited to:

    - Development of a POT, based upon the primary care physician's written orders for the home program. The POT is to include that the beneficiary is on the IHMC Waiver, all waiver services authorized by the Department and all other services being provided to the beneficiary while under the IHMC Waiver. These services may also include Medi-Cal related services, such as equipment, supplies, transportation, and Adult Day Health Care; services through California Children's Services, such as therapies; regional center services, such as respite; services provided through other public entities, such as In-Home Supportive Services (IHSS), and private entities.

- Maintain documentation, subject to the Department's review and approval, acknowledging compliance with the developed POT.

- Evaluate and document that the beneficiary's residence is appropriate and adequate for the delivery of waiver services, which will ensure both the health and safety of the beneficiary and the provider of service(s). This documentation shall be in a format acceptable to the Department and will include the following:

  - Assessment of the area in which the beneficiary will be cared for and the area(s) to be used for the maintenance, cleaning, and storing of supplies and equipment;
  - Assessment of primary and back-up utility services, communication systems, fire safety systems and devices, such as grounded electrical outlets, smoke detectors, a fire extinguisher, and a functional telephone;
  - Development of an emergency back-up plan appropriate to the area of residence and the types of emergencies that are known to occur in the area. This plan requires that a party be designated to notify the local utility companies, the emergency response systems, the fire department, and any local rescue organizations that the beneficiary has special medical needs that may require assistance in case of an emergency.

- Notify the Department in a timely manner of any changes reported to the Department of Licensing and Certification (California Code of Regulations, Title 22, Division 3, Section 74667). This notification is required by all HCBS providers who are licensed and certified home health agencies, and applies to changes that impact the health, safety, or welfare of the beneficiary.

4. The Department (IHO) will:

- Work cooperatively with the beneficiary and/or the primary caregiver, the HCBS waiver service provider(s), the primary care physician, and all other providers of Medi-Cal services to help ensure a successful home program. This would also include collaboration on linking the beneficiary with other programs and supports, and problem resolution, as warranted.

- Assist as warranted in the identification of supports needed to ensure the health and safety of this individual while under this waiver.

- Conduct home visits that may or may not be announced to assess the home program and any issues related to the home program. Unannounced visits shall be conducted, as deemed necessary by the Department, to assess the health and safety of the beneficiary.

(Beneficiary)
Page
Date

- Modify, reduce, deny, or terminate IHMC Waiver services should any one of the following occur:

  - The cost of the requested service(s) exceeds the cost of the identified institutional alternative and the beneficiary and/or the primary caregiver does not agree to a reduction in the requested services in order to maintain program cost-neutrality;

  - The beneficiary loses Medi-Cal eligibility;

  - The beneficiary dies;

  - The beneficiary or his/her authorized representative elects in writing to terminate IHMC Waiver services;

  - The beneficiary moves from the geographical area in which the IHMC Waiver services were being authorized, and in the new area there are providers of services but no provider has agreed to render waiver services to the beneficiary;

  - The beneficiary's condition is unstable as demonstrated by repeated, unplanned hospitalizations;

  - The beneficiary's condition improves to the point that he/she no longer meets the medical eligibility criteria for the IHMC Waiver services, i.e., the level of care has changed;

  - The beneficiary or the primary caregiver refuses to comply with the primary care physician's orders on the POT and the Department determines that such compliance is necessary to assure the health and safety of the beneficiary;

  - The beneficiary or the primary caregiver does not cooperate in attaining or maintaining the plan of treatment goals;

- The identified support network system or the primary caregiver can not be identified, is not able, or is no longer willing or available to assume the responsibility to act as a back-up for the beneficiary; The MCOD-IHO nurse case manager will work with the beneficiary and responsible persons to develop a plan of treatment and identify providers so the beneficiary can continue to reside safely in a home-like setting, when possible. Every responsible effort will be made by the MCOD-IHO nurse case manager in establishing case management services for beneficiaries who elect only HCBS PCS benefit.

- The home assessment fails to demonstrate an environment that supports the beneficiary's health and safety or is otherwise not conducive to the provision of HCBS waiver services. The home safety assessment will be determined through a home safety evaluation completed by the HCBS provider;

- The HCBS waiver service provider is unwilling or unable to provide the amount of authorized services as required by the beneficiary's treatment plan and/or physician's order. This inability to provide services may impact the quality of the service(s) provided. Therefore, if requested to do so by the beneficiary and/or the authorized representative, the Department shall assist with the authorization process for the beneficiary at the otherwise appropriate licensed health care facility, until another HCBS waiver service provider accepts the responsibility for providing services in the home setting; and,

(Beneficiary)
Page
Date

- Any documented incidence of noncompliance by any party with the requirements of this agreement that poses a threat to the health or safety of the beneficiary, and/or any failure to comply with all regulatory requirements.

  Questions regarding this notice should be directed in writing to the following address:

  Department of Health Services
  Home- and Community-Based Services Branch
  In-Home Operations Section
  1501 Capitol Avenue, MS 4502
  P.O. Box 997419
  Sacramento, CA 95899-7419

  Telephone inquiries should be directed to the following number: (916) 552-9271.

  Your interest as a participant in the IHMC Waiver is appreciated.

Sincerely,

Paul Miller, Chief
In-Home Operations Section

Enclosure

cc: Name, R.N.
Nurse Evaluator II
In-Home Operations

Attachment 9, Notice of Action and/or Request for Fair Hearing

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

NOTICE OF ACTION: (JvR3)

To: {Beneficiary Name}
{Address1}
(Address2}
{Address3}
{Address4}

TAR No.:_____
Expiration Date:_____
Medi-Cal No.:_____
Facility:_____

The Medi-Cal Field Office has taken the following action with respect to services requested by your doctor or other Medi-Cal provider. Provider name and address:

☐ 1. Denied further Medi-Cal payment for _____ services effective _____. The Medi-Cal program previously approved payment for these services for the period _____ through _____.

☐ 2. Denied some portion of the services requested. The Medi-Cal program previously approved payment for services for the period _____ through _____ as follows: _____. The Approval of these services has been modified beginning _____ as follows:

The reason and legal basis for this decision is as follows:

☐ 1. Your current medical condition and/or medical needs as described by your medical provider do not meet the definition of "medical necessity" as set forth in Title 22, California Code of Regulations (CCR), Section 51303(a).

☐ 2. The service requested does not meet the requirement for the lowest cost item or service that meets your medical needs covered by Medi-Cal program as set forth in Title 22, California Code of Regulations, Section 51003(f).

☐ 3. Other (Explain and cite regulations.)

If you do not agree with the above action, you or your authorized representative have the right to request a State Hearing within ninety (90) days of the date of this notice. Please see the back of this notice for information on how to request a State Hearing. Also, please see the attached notice concerning additional appeal rights that you have.

This notice does not affect your eligibility for Medi-Cal. You will continue to receive your Medi-Cal card and the covered Medi-Cal services for which you have a medical need.

Medi-Cal Field Office Representative: _____

White Copy — Beneficiary; Canary — Provider; Pink — Field Office; Goldenrod — Headquarters

1501 Capitol Avenue, MS 4502; P.O. Box 997419; Sacramento, CA 95899-7419
(916) 552-9271
Internet Address: www.dhs.ca.gov

State of California—Health and Human Services Agency

Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

NOTICE OF ACTION: (FvK1)
Denial Constituting a Termination or Reduction of Previously Approved Services

To: {Beneficiary Name}
{Address1}
(Address2}
{Address3}
{Address4}

TAR No.:_____
Expiration Date:_____
Medi-Cal No.:_____
Facility:_____

The Medi-Cal Field Office has taken the following action with respect to services requested by your doctor or other Medi-Cal provider. Provider name and address:

☐ 1. Denied further Medi-Cal payment for _____ services effective _____. The Medi-Cal program previously approved payment for these services for the period _____ through _____.

☐ 2. Denied some portion of the services requested. The Medi-Cal program previously approved payment for services for the period _____ through _____ as follows: _____. The Approval of these services has been modified beginning _____ as follows:

The reason and legal basis for this decision is as follows:

☐ 1. Your current medical condition and/or medical needs as described by your medical provider do not meet the definition of "medical necessity" as set forth in Title 22, California Code of Regulations (CCR), Section 51303(a).

☐ 2. The service requested does not meet the requirement for the lowest cost item or service that meets your medical needs covered by Medi-Cal program as set forth in Title 22, California Code of Regulations, Section 51003(f).

☐ 3. Other (Explain and cite regulations.)

If you do not agree with the above action, you or your authorized representative have the right to request a State Hearing within ninety (90) days of the date of this notice. Please see the back of this notice for information on how to request a State Hearing.

f you request a State Hearing before the expiration date at the top of this notice or within ten (10) days of the date of this notice, whichever is later, Medi-Cal will continue to approve the requested services until a State Hearing decision is made.

This notice does not affect your eligibility for Medi-Cal. You will continue to receive your Medi-Cal card and the covered Medi-Cal services for which you have a medical need.

Medi-Cal Field Office Representative: _____

White Copy — Beneficiary; Canary — Provider; Pink — Field Office; Goldenrod — Headquarters

1501 Capitol Avenue, MS 4502; P.O. Box 997419; Sacramento, CA 95899-7419
(916) 552-9271
Internet Address: www.dhs.ca.gov

YOUR HEARING RIGHTS

To Ask for a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we gave or mailed you this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To keep Your Same Benefits While You Wait for a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the State information number.

Call toll free: 1-800-952-5253

If you are deaf and use TDD call: 1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services, and the U.S. Department of Agriculture. (W & I Code Section 10950)'

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

Administrative Adjudications Division
State Department of Social Services
744 P Street, Mail Station 19-37
Sacramento, CA 95814

Los Angeles County residents (only) send to:
Fair Hearings Section
P.O. Box 10280
Glendale, CA 91209

Your worker will get you a copy of this page if you ask. Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call: 1-800-952-8349.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department.

of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal ☐ Child Care

☐ Other (list)

_____

Here's why:

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or come to the hearing for me.

NAME _____

ADDRESS _____

_____

☐ I need a free interpreter.

My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature: _____

Date: _____

APPENDIX E, PLAN OF TREATMENT

Appendix E-1, Plan of Treatment

Plan of Treatment Development

1. The following individuals are responsible for the preparation of the plans of care/plan of treatment (POT):

   _X_ Registered nurse, licensed to practice in the State who is either:

   a. Employed by the HHA or

   b. Under the direction of a licensed physician

   ____ Licensed practical or vocational nurse, acting within the scope of practice under State law

   _X_ Physician (M.D. or D.O.) licensed to practice in the State who is also the primary care physician of the beneficiary.

   _X_ Marriage and Family Therapist (MFT), Licensed Psychologist, Licensed Clinical Social Worker (LCSW) or a professional corporation made up of MFTs, Licensed Psychologists, or LCSWs. (See Appendix B-2 and B-4 for qualifications)

   ____ Case Manager

   _X_ Other (specify): A Registered Nurse, licensed to practice in the State and who is an employee of MCOD-IHO to consult with the provider of waiver services in the development and review of the POT.

   The development of the POT will include input from the beneficiary and, if appropriate, the authorized representative.

2. Copies of written plans of treatment will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of treatment will be maintained.

   _X_ At the Medicaid agency central office or the designated Medi-Cal office.

   ____ At the Medicaid agency county/regional offices

   _X_ By case managers employed by MCOD-IHO.

   _X_ By the agency specified in Appendix A

   _X_ By consumers

_X_ Other (specify): Copies of the POT will be maintained by the waiver service provider at their place of business.

3. The plan of treatment is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

    ____ Every 3 months

    ____ Every 6 months

    ____ Every 12 months

    _X_ Other (specify): At the time of the initial request and for each subsequent reauthorization. Services under the IHMC Waiver may be reauthorized for up to 180 days.

    A POT is required to be submitted by the waiver service provider with the initial and all reauthorization requests for services. The POT is submitted to the designated Medi-Cal office along with the Treatment Authorization Requests (TAR). The POTs are reviewed and updated at the provider level, as specified in established regulations and in a manner consistent with applicable license and certification requirements necessary for the delivery of services. Additionally, when the MCOD-IHO case manager conducts the required home visit, periodicity to be determined as explained in Appendix D of this application, the POT will be reviewed. This home visit and POT review will be documented on the "Case Management Report" form.

Appendix E-2, Medicaid Agency Approval

a. Medicaid Agency Approval

The following is a description of the process by which the plan of treatment is made subject to the approval of the Medicaid agency:

The POT is submitted to the appropriate Medi-Cal office with a TAR as part of the initial request for services. The POT is updated at the time of reauthorization, when there are changes in the condition of the beneficiary or when there are updates or changes made to the authorized services. The POT is developed and submitted to the MCOD-IHO nurse case managers for review of continued medical necessity and compliance with requirements outlined in Title 22, CCR, Sections 51003, 51337 and 74697.

The TAR for reauthorization of services is submitted every 180 days by the authorized waiver service(s) provider. Each request for reauthorization of services is accompanied by a current POT and MOHS plan. Prior authorization, reauthorization or approval granted by a designated Medi-Cal consultant is required in advance of the rendering any IHMC Waiver service.

Statutory Requirements and Copy of Plan of Treatment

1. The plan of treatment will contain, at a minimum, the type of services to be furnished, the amount, the frequency, and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of treatment form to be utilized in this waiver is attached to this Appendix. All HCBS waiver providers will be required to utilize the POT developed by MCOD-IHO.

    a. The HCFA-485, "Home Health Certification and Plan of Treatment" may be used on an interim basis the plan of treatment. The primary waiver service provider in collaboration should complete the document with the beneficiary and the primary care physician. The amount, duration, and frequency of all prescribed services – waiver and non-waiver – will be on the plan of treatment.

    For purposes of providers who use the Form HCFA-485, the amount, duration, and frequency of all prescribed services – waiver and non-waiver - will be listed in item #21 of the Form HCFA-485, labeled "Orders for Discipline and Treatments". The plan of treatment is submitted to the appropriate MCOD-IHO office when services are first requested and thereafter for reauthorization of continued services. The plan of treatment is to be developed using criteria outlined in Title 22, CCR, Section 74697.

    The MCOD-IHO staff reviews these documents for appropriate care planning for the beneficiary as well as delivery of services by the appropriate provider types based upon acceptable standards within the nursing community. Any necessary revisions are discussed with the provider of service, the physician, and beneficiary as needed.

b. The providers who use the Form HCFA-485 will be instructed to write "Non applicable" in item # 26 of the form.

Appendix E-2, Attachment

Plan of Treatment and Instructions for Completion

Medi-Cal In-Home Operations Section
Home and Community-Based Services (HCBS) Branch
Plan of Treatment (POT)

1. BENEFICIARY INFORMATION

Name: Last Name First Name SSN: - - DOB: / / M ☐ F ☐
Last First
Address: Beneficiary's Address Phone #: ( ) -
Area code
City State Zip code

If Applicable
Medical Record #: Primary Caregiver: Beneficiary's Primary Caregiver

(Applicable for providers who use Medical Record #'s) Relationship to Beneficiary: Relationship to Beneficiary

Primary Language: Of the Beneficiary

2. PROVIDER INFORMATION

Name of the Provider Title: Provider's Title
Name:

Address: Provider's Address Phone #: ( ) -
Area code
City State Zip code

Provider #: Provider ID # Fax #: ( ) -
Area code

Start of Care Date: / / ***Treatment Period**: / / / /
(May cover up to 180 days maximum) FROM TO:

3. PRIMARY CARE PHYSICIAN

Name: Primary Care Physician's Name

Address: Primary Care Physician's Address Phone #: ( ) -
Area code
City State Zip code

Fax #: ( ) -
Area code

***Note: The treatment period may be less than the 180 days depending upon licensure or certification requirements of rendering provider.**

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

4. MEDICAL INFORMATION – Include ICD-9 codes where appropriate.

Please add additional pages as needed.

Beneficiary's Primary Diagnosis _____ _____ Date of onset: / /
Primary Diagnosis ICD-9

If secondary diagnosis - please include _____ _____ Date of onset: / /
Secondary Diagnosis ICD-9

Please list other diagnosis here _____ _____ Date of onset: / /
Other Diagnosis ICD-9

Please list other diagnosis here _____ _____ Date of onset: / /
Other Diagnosis ICD-9

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. MEDI-CAL HOME AND COMMUNITY-BASED PROGRAM

Please check all that apply.

☐ Nursing Facility (NF) A/B Waiver ☐ NF Subacute (SA) Waiver ☐ In-Home Medical Care (IHMC) Waiver

☐ Early Periodic, Screening, Diagnosis and Treatment (EPSDT) ☐ Pediatric Day Health Care (PDHC)

6. Level of Care (LOC)

Please check only one.

NOTE: The LOC determination will be made by the Medi-Cal In-Home Operations Section and provided to the provider.

☐ Acute ☐ ICF/DDH ☐ NF-B (DP)

☐ Adult Subacute ☐ ICF/DDN ☐ Pediatric Subacute non-ventilator dependent

☐ **ICF/DD** ☐ NF-A ☐ Pediatric Subacute ventilator dependent

☐ NF-B

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

7. WAIVER SPECIFIC SERVICES

Please check all that apply and enter the appropriate frequency key code.
(Only complete this section if enrolled in a HCBS Waiver program.)

Service	Frequency Key Code:		
	D=Daily	W=Weekly	If other
	Y=Yearly	M=Monthly	please describe below
	O=Other		
☐ Case Management	Please Choose One		If other, please describe
☐ Environmental Accessibility Adaptations	Please Choose One		If other, please describe
☐ Family Training	Please Choose One		If other, please describe
☐ Personal Emergency Response Systems	Please Choose One		If other, please describe
☐ Private Duty/Individual/Shared Nursing Care	Please Choose One		If other, please describe
☐ Certified Home Health Aide Services	Please Choose One		If other, please describe
☐ Respite	Please Choose One		If other, please describe
☐ Utility Services	Please Choose One		If other, please describe
☐ Personal Care Services under the Waiver	Please Choose One		If other, please describe
☐ Waiver Service Coordination	Please Choose One		If other, please describe

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

8. NON-WAIVER SERVICES

Include all applicable services and frequency. May include those services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services.

Examples include: Adult Day Health Care, Pediatric Day Health Services, Medical Therapy Program, Housing Referrals, Social Service Referrals, and Vocational Rehabilitation.
Please add additional pages as needed.

Please use additional pages as needed

9. MEDICATION PLAN FOR HOME PROGRAM

Space for additional medications provided on Page 5.

Allergies: List any beneficiary allergies, please use additional paper if needed _____ Reaction (if known): Please list the reaction from allergies _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

Medication: _____ Dose: _____ Route: _____ Frequency _____

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

9a. ADDITIONAL MEDICATIONS

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: ____________ Dose: ________ Route: ________ Frequency ________

Medication: Dose: Route: Frequency

Who gives the medications to the patient? ie: self, family, nurse, caregiver

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

10. NUTRITIONAL REQUIREMENTS

Please include type of diet, method of feeding, amount and frequency.

Please use additional pages as needed

11. TREATMENT PLAN FOR HOME PROGRAM:

Include all needed services, frequency, and duration of service and provider(s) of service(s).
Space for additional orders provided on Page 7.

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

11a. TREATMENT PLAN FOR HOME PROGRAM – CONTINUED ADDENDUM

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

12. FUNCTIONAL LIMITATIONS

Please describe functional limitations per the physician order within each category.
Please add additional pages as needed.

☐ No limitations noted.

MOTOR: May include limitations with walking and/or gross motor movement.

Please use additional pages as needed

☐ No limitations noted.

SELF HELP: May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

Please use additional pages as needed

☐ No limitations noted.

COMMUNICATION/SENSORY May include limitations with hearing, speech, and sight.

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

13. ACTIVITIES

Include permitted activities per the physician order such as up with assistance, complete bedrest, up as tolerated, use of adaptive equipment such as wheelchair, walker, etc.

☐ No restrictions on activities.

Please use additional pages as needed

Safety precautions in use: ☐ Seizure precautions ☐ Universal precautions ☐ Other:
Rehabilitation Potential: ☐ Good ☐ Fair ☐ Poor

14. MENTAL STATUS

May include information related to behavior and/or cognition such as aggression, depression, agitation, confusion, and developmental disabilities.

☐ No limitations noted – oriented to name, date, place and time.

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

15. DURABLE MEDICAL EQUIPMENT

Include all types of equipment used, provider of equipment, and funding source (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

16. MEDICAL SUPPLIES

Include all types of supplies, provider of supplies, and funding source (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

17. THERAPIES/REFERRALS

Check all that apply and please include date the referral was made and why.
If therapy is ongoing, please indicate the current progress/status in Section 20.

☐ Physical Therapy Date / / Referral Reason _____

☐ Occupational Therapy Date / / Referral Reason _____

☐ Speech Therapy Date / / Referral Reason _____

☐ Enterostomal Therapy Date / / Referral Reason _____

☐ Medical Social Worker Date / / Referral Reason _____

☐ Nutritionist Date / / Referral Reason _____

☐ Other/List Date / / Referral Reason _____

☐ Other/List Date / / Referral Reason _____

☐ Other/List Date / / Referral Reason _____

18. TREATMENT GOALS/DISCHARGE PLAN

Please check only one.

☐ Upon completion of treatment plan, the beneficiary will be able to function independently and maintain self safely in the home setting.

☐ Upon completion of this treatment plan, the beneficiary will continue to need
☐ Minimal ☐ Moderate ☐ Maximum support to be maintained safely in the home setting.

Describe specific goals and discharge plan as related to the identified needs:

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

19. TRAINING NEEDS FOR BENEFICIARY/FAMILY

☐ No training needs have been identified for the beneficiary and/or the family during this treatment period.

☐ Yes, there are training needs for the beneficiary and/or family during the treatment period.

(If yes boxed checked, please describe the training needs and name of the provider)

Please use additional pages as needed

20. SUMMARY OF BENEFICIARY STATUS DURING THIS TREATMENT PERIOD

Please use additional pages as needed

In-Home Operations Section
Home and Community-Based Services Branch
Electronic Plan of Treatment
Beneficiary's Name:
Treatment Period:
FROM **TO**

21. After completing, please print and obtain original signatures. Keep the original and mail a copy to the attention of the appropriate IHO Regional Office and the Medi-Cal In-Home Operations assigned Nurse Case Manager.

Beneficiary Signature	**Date** / /
Primary Caregiver Signature (as applicable)	**Date** / /
Physician Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /
Provider Signature	**Date** / /

Medi-Cal In-Home Operations (IHO) Section
Home and Community-Based Services (HCBS) Branch
Instructions for the Plan of Treatment (POT) Document

MEDI-CAL IN-HOME OPERATIONS (IHO) SECTION HOME AND COMMUNITY-BASED SERVICES (HCBS) BRANCH INSTRUCTIONS FOR THE PLAN OF TREATMENT (POT) DOCUMENT

The HCBS POT is a Word-based document that can be filled out either electronically or manually. This POT can be used for Medi-Cal beneficiaries receiving services through one of the HCBS Waivers administered by IHO and/or Private Duty Nursing (PDN) services through the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Below are general directions for each section of the form.

The ***Comments*** section may be used throughout the document to provide explanatory information as necessary. The completed POT must obtain original signatures from the beneficiary or their legal representative, Primary Care Physician, and for HCBS waiver beneficiaries, all the HCBS Waiver service provider(s), i.e., personal caregiver, Home Health Agency (HHA), Independent Nurse Provider (INP), etc. or for EPSDT beneficiaries all the INPs. Once all signatures have been obtained, keep the original and return a signed copy of this document to the appropriate IHO Regional Office.

Step 1 (For the electronic version only.)

*(**Note:** For the manual version go to step 2)*

a. **Unlock** the document:

- Go to the **View** menu, click on **Toolbars** and then click on **Forms**.
- A √ should appear next to **Forms**.
- The Forms toolbar will appear with the **LOCK** button turned on. In the "Locked" mode, the button will have a light gray background.
- Click on the **LOCK** button. In the "Unlocked" mode the button will have a medium gray background.

b. Complete the header at the top of page 2 by entering the beneficiary's name and the treatment period "from and to" dates.

- How to access the header (2 methods):

1. Go to page 2. Using your mouse, double click on the header and enter the information. To exit this function, using your mouse, double click in any area out side of the header. This information will auto-fill on the subsequent pages.

   or

2. Go to the **View** menu, click on **Header and Footer** and scroll down to page 2. Enter the information in the Header. To exit this function, go back to the menu bar. Click on **View**. Click on the √ next to **Header and Footer**.

c. **Lock** the document. Click on the **LOCK** button. The button background will change to light gray.

d. Complete the POT as instructed below in step 3.

Helpful hints for using the electronic version.

This document has been developed with check boxes, drop-down menus, and locked fields.

- **Do not use the *ENTER/RETURN* key, as it will alter the formatting and disrupt the spacing throughout the document**.
- Check boxes. The check boxes can be marked with an "X" by placing the cursor over the box and single clicking it using the mouse.
- Drop-down menus. The drop-down menus can be accessed by placing the cursor over the box, single clicking it with the mouse and selecting the appropriate response. The only drop-down menus present on the POT are found in section 7. **Waver Specific Services**.
- Locked fields. The locked fields appear as gray shaded areas and are preset to tab through the document. You can use your mouse to maneuver around the document.
- Be sure that the ***LOCK*** button is turned on. If the ***LOCK*** button is turned off before completion, the form will not work properly.
- Spell Check. In order to spell check the document, the POT must be entirely completed and the ***LOCK*** button must be turned **OFF**. Go to the **Tools** menu and click on **Spelling and Grammar**. Once the spell check is complete, you can choose to save the document by going to the **File** menu and clicking on **Save As**….

IMPORTANT: If the ***LOCK*** button is turned back **ON** after any information has been entered on the POT, it will delete **all** of the information you have entered on the POT.

Step 2 (Manual version)

a. On pages 2 through 13, complete the header by entering the beneficiary's name and the treatment period "from and to" dates.

b. Complete the POT as instructed below in step 3.

Step 3: Completing the HCBS Branch POT (Electronic and Manual versions)

Section 1: Beneficiary Information

Please complete as indicated. The ***medical record number*** of the beneficiary is optional and is for the provider's use for filing purposes. The ***primary language*** may include the primary caregiver's primary language, if different from that of the beneficiary.

Section 2: HCBS Provider Information

Please complete as indicated. The ***provider*** name is the name of the agency or individual who is primarily responsible for the services described in the POT. This would include the HHA, Case Manager (CM), Professional Corporation (PC), or the lead Individual Nurse Provider (INP) LVN for beneficiaries receiving EPSDT Private Duty Nursing (PDN) services without R.N. Case Management. The ***treatment period*** may vary depending upon licensure and/or certification requirements of the provider.

Section 3: Primary Care Physician

Please complete as indicated. The ***Primary Care Physician*** is the physician signing the POT.

Section 4: Medical Information

Please complete as indicated. Include ***ICD-9 codes*** or diagnosis codes where appropriate. The ***"other"*** section may be used if there are other diagnoses pertaining to this beneficiary.

You may contact the MD to obtain the diagnosis and ICD9 codes.

For the ***prognosis,*** please check only one of the boxes (excellent, good, fair, or poor).

Section 5: Medi-Cal Home and Community-Based Program

Please check all the appropriate programs for which services are being requested. You may contact the IHO Case Manager for the appropriate program information.

Section 6: Level of Care (LOC)

The **LOC determination will be made by the Medi-Cal In-Home Operations Section** and provided to the provider (HHA, CM, PC or INP). Please check ***only one box***—once information is provided.

Section 7: Waiver Specific Services

* Note: **This section is not completed for beneficiaries who are only receiving EPSDT PDN services.**

Please complete as indicated. All the ***Waiver Specific Services*** are listed in this section. Please check all of the services the beneficiary is utilizing. If you are using the document electronically, please click on the arrow under the ***Frequency Key Code***, and double-click the appropriate ***Key Code***. If ***"other"*** is used, then please describe.

Section 8: Non-Waiver Services

For beneficiaries enrolled in one of IHO's HCBS Waivers, federal regulations require that all non-waiver services the beneficiary is receiving be described in their POT. The description of the services includes the amount, frequency and who provides the service. ***Non-waiver services*** may include services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services. ***Examples***: Adult Day Health Care (ADHC), Pediatric Day Health Care (PDHC), Social Services Referrals, Medical Therapy Program, Housing Referrals, Respite and Vocational Rehabilitation.

Section 9: Medication Plan for Home Program

Please complete as indicated. This includes prescription and non-prescription medications. Space for additional medications is provided on Page 5 of the POT.

Section 9a: Medication Plan for Home Program – Additional Page

Section 10: Nutritional Requirements

Please describe nutritional requirements for the beneficiary as ordered by the physician. Please indicate type of diet, method of feeding, amount, and frequency.

Section 11: Treatment Plan for Home Program

MD orders must identify all services rendered by the provider.

Please list/describe all services provided including:

- The provider of services.
- The provider type.
- The amount and frequency of the services.

- The type of services provided.

Space for additional orders can be provided on Page 7 of the POT.

Section 11a: Treatment Plan for Home Program – Continued

Section 12: Functional Limitations

Please describe functional limitations as per the physician's order within each category. If ***"no"*** limitations are noted, please check the appropriate box and proceed to Section 13.

Motor (examples: amputation, contracture, paralysis, ambulation, partial weight bearing, crutches, cane, wheelchair, walker)

Self-help (examples: incontinent of bowel/bladder, independent at home)

Communication/Sensory (examples: hearing, speech, legally blind, glasses)

Section 13: Activities

Please describe activities of the beneficiary as per the physician's order. (Examples: Endurance, dyspnea with exertion, complete bedrest, bedrest BRP, up as tolerated, exercises prescribed). If ***"no"*** restrictions on activities are noted, please check the appropriate box and proceed to Section 14.

Section 14: Mental Status

Please summarize the mental status of the beneficiary. (Examples: comatose, forgetful, depressed, disoriented, lethargic, agitated, developmentally delayed). If ***"no"*** limitations are noted, please check the appropriate box and proceed to Section 15.

Section 15: Durable Medical Equipment

Please list all types of equipment used, providers of equipment, and funding sources such as Medi-Cal, private insurance, Medicare. ***(if known)***.

Section 16: Medical Supplies

Please list all types of supplies, providers of supplies, and funding sources such as Medi-Cal, private insurance, Medicare. ***(if known)***.

Section 17: Therapies/Referrals

Please check all types of therapy that apply, the date each referral was made, and the reason(s) why the referral was made. If ***therapy is ongoing***, please indicate the current progress/status in Section 20. If the type of therapy is ***not listed***, please use the **other/list**.

Section 18: Treatment Goals/Discharge Plan

Please check the appropriate box. If you select the 2nd box, you must describe the level of support needed, i.e., Minimal, Moderate, or Maximum.

Describe specific goals and discharge plans that are identified in the POT, i.e., beneficiary will be able to self-direct caregivers in trach care, primary caregivers will be knowledgeable in diabetic management, or caregivers will be knowledgeable in pressure relief.

Section 19: Training Needs for Beneficiary/Family

Please check ***only one*** box for training needs. If you choose ***"yes"***, please use the area provided to describe the training needs of the beneficiary/family and list the name of the provider(s).

Section 20: Summary of Beneficiary Status during this Treatment Period

Please summarize the ***status of the beneficiary*** during this treatment period for the POT. This area may also be used, as stated in Section 17, to describe current progress/status of ongoing therapy. Each INP is to provide a summary of the care they provided and the overall status of the beneficiary. Include the beneficiary's response to their POT and any significant changes.

Signature Section

Please complete the POT Form, then print, and ***obtain original signatures*** from the following:

- The physician who oversees beneficiary's home program
- The beneficiary or their legal representative
- Primary Caregiver (i.e. parent , spouse, family member)
- All providers of HCBS Waiver services (this can include: HHA, Waiver Personal Care Providers, INPs, Professional Corporation, and the CM)
- ALL INPs for beneficiaries who are only receiving INP services through the Medi-Cal EPSDT benefit

Keep the original, make a copy, and ***return the copy by mail to the attention*** of the appropriate IHO Regional Office, and assigned IHO Nurse Case Manager as listed below:

Name of IHO Nurse Case Manager
In-Home Operations Section
Department of Health Services
1501 Capitol Avenue, MS 4502
P.O. Box 997419
Sacramento, CA 95899-7419

Name of IHO Nurse Case Manager
In-Home Operations Section
Department of Health Services
311 South Spring Street, Suite 313
Los Angeles, CA 90013-1211

APPENDIX F, AUDIT TRAIL

Description of Process

a. Description of Process

1. As required by Sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by Section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   _____ Payments for all Waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   __X__ Payments for most, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers described in the attachment to this Appendix.

   _____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   _____ Other (Describe in detail):

b. Billing and Process and Records Retention

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of treatment;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

      _____ Yes __X__ No, these services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   _____ All claims are processed through an approved MMIS.

   __X__ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. Payment Arrangements

1. Check all that apply:

   __X__ The Medicaid agency will make payments directly to providers of waiver services.

   __X__ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

   _____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

   _____ Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify):

   Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

Appendix F, Billing Process and Records Retention

Billing Process and Records Retention

The State of California assures CMS that the Department will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver and it will maintain and make available to the U.S. Department of Health and Human Services, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

California Medicaid Management Information System (CA-MMIS)

All HCBS waiver services are subject to the requirements established under the CA-MMIS system. CA-MMIS provides two basic functions to assure financial accountability of the waiver program:

1. CA-MMIS serves as the automated claims processing system for HCBS waiver claims. CA-MMIS verifies recipient Medi-Cal eligibility, waiver enrollment, and payment only to Medi-Cal waiver service providers; and
2. CA-MMIS produces the data from paid waiver claims to produce the data for the HCFA-372 Report sections specific to waiver recipients and expenditures. This automated claims payment processing system contains information on the number of recipients by level of service, and actual expenditures for all waiver services.

The State's fiscal intermediary will maintain this automated billing system. The automated billing system will follow standard Medicaid billing procedure. In addition to the normal claims processing, the automated billing system will contain the following elements:

1. Unique service codes including definitions and rates for each service provided under the waiver.
2. Edits and audits to assure that only authorized waiver service providers bill for services. CA-MMIS subjects all claims to duplicate billing checks, and CA-MMIS has the ability to suspend claims for conflicting or overlapping codes.
3. Edits that prevent waiver services from being claimed while a recipient is institutionalized.

All HCBS waiver services will require prior authorization through the State's standard utilization review system using the Treatment Authorization Request (TAR) system.

Quality Control/Quality Assurance

Quality control/quality assurance reviews will be performed periodically by DHS-MCOD Quality Assurance Unit to ensure that waiver services have received prior authorization, been appropriately billed, and are cost effective. Any billing discrepancies will be reported to the Department's Payment Systems Division, which is responsible for oversight of the State's fiscal intermediary.

APPENDIX G, FINANCIAL DOCUMENTATION

Appendix G-1, Composite Overview

Cost Neutrality Formula

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g., hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

Level of Care: Hospital

Year	Factor D	Factor D'	Factor G	Factor G'
1	$248,670	$35,202	$305,283	$8,773
2	$256,663	$36,258	$322,422	$9,036
3	$187,998	$36,805	$450,114	$39,324
4	$191,760	$37,541	$459,116	$40,110
5	$195,593	$38,292	$468,299	$40,913

Factor C: Number of Unduplicated Individuals Served

Level of Care: Hospital

Waiver Year	Year	Unduplicated Individuals
1	2003/2004	200
2	2004/2005	250
3	2005/2006	300
4	2006/2007	350
5	2007/2008	400

Explanation of Factor C:

Check one:

_X_ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

____ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit that is less than factor C for that waiver year.

Assumptions for Factor C:

Sixty-five persons are enrolled in the IHMC Waiver as of April 1, 2005.

- The maximum enrollment cap for the IHMC Waiver will not increase above the previously approved for Waiver Years 3, 4 and 5.
- Consistent with past experience, DHS does not anticipate exceeding the approved annual cap on unduplicated recipients.
- As of April 1, 2005, there is no waiting list for enrollment in the IHMC Waiver. Persons requesting IHMC Waiver enrollment, which would exceed the approved enrollment cap, will be placed on a waiting list.
- Historically enrollment in the IHMC Waiver is about 90% adults and 10% children (pediatric).
- Growth is anticipated to be 50 unduplicated beneficiaries annually.
- Annually, DHS will review the demand and requests for IHMC Waiver enrollment to determine the need to amend the Waiver to increase the cap on enrollment.

Appendix G-2, Methodology for Derivation of Formula Values, Factor D

Level of Care: Hospital

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

Assumptions for Factor D have been based on a combination of utilization experience with the IHMC waiver during the periods 07/01/02 – 06/31/03 and 07/01/03 – 06/30/04 and the experience of the MCOD's other HCBS waivers. Factor D assumes that:

Distribution of Services

Of the sixty-five beneficiaries enrolled in the IHMC waiver, approximately 10 percent are under the age of 21. Those under age 21 only receive services under the waiver that are not available under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. Eligible individuals will be enrolled in this waiver up to the number indicated as factor C for the waiver year as an alternative to being admitted to an acute facility in their community. The table below describes the projected rate of utilization for each waiver service for persons 21 years of age and over and those under 21 years of age.

Expected Rates of Utilization of In-Home Medical Care Waiver Services for Persons Under 21 Years of Age and 21 Years of Age and Over

Waiver Service	Under	21 & Over
Case Management, HCBS Benefit Provider-LCSW	0.0%	2.0%
Case Management, HCBS Benefit Provider-Licensed Psychologist	0.0%	2.0%
Case Management, HCBS Benefit Provider-MFCC	0.0%	2.0%
Case Management, HCBS Waiver-RN	0.0%	5.0%
Case Management, HHA-RN	0.0%	80.0%
Case Management, Professional Corporation	0.0%	2.0%
Environmental Accessibility Adaptations	5.0%	5.0%
Family Training, HCBS Waiver-RN	2.0%	2.0%
Family Training, HHA	3.0%	4.0%
Personal Emergency Response System	6.0%	6.0%
Private Duty Nursing, HCBS Nursing Facility (CLHF)	0.0%	20.0%
Private Duty Nursing, HCBS Waiver-LVN	0.0%	10.0%
Private Duty Nursing, HCBS Waiver-LVN, Shared	0.0%	2.0%
Private Duty Nursing, HCBS Waiver-RN	0.0%	5.0%
Private Duty Nursing, HCBS Waiver-RN, Shared	0.0%	2.0%

Expected Rates of Utilization of In-Home Medical Care Waiver Services for Persons Under 21 Years of Age and 21 Years of Age and Over		
Waiver Service	**Under**	**21 & Over**
Private Duty Nursing, HCBS Waiver-RN, Supervision	0.0%	10.0%
Private Duty Nursing, HHA-CHHA	0.0%	60.0%
Private Duty Nursing, HHA-CHHA, Shared	0.0%	2.0%
Private Duty Nursing, HHA-LVN	0.0%	60.0%
Private Duty Nursing, HHA-LVN, Shared	0.0%	2.0%
Private Duty Nursing, HHA-RN	0.0%	10.0%
Private Duty Nursing, HHA-RN, Shared	0.0%	2.0%
Respite, Acute Care Hospital	1.0%	1.0%
Respite, HCBS Nursing Facility (CLHF)	1.0%	2.0%
Respite, HCBS Waiver-LVN	1.0%	1.0%
Respite, HCBS Waiver-RN	1.0%	1.0%
Respite, HHA-CHHA	1.0%	1.0%
Respite, HHA-LVN	1.0%	1.0%
Respite, HHA-RN	1.0%	1.0%
Transitional Case Management, HCBS Benefit Provider-LCSW	1.0%	1.0%
Transitional Case Management, HCBS Benefit Provider-Licensed Psychologist	1.0%	1.0%
Transitional Case Management, HCBS Benefit Provider-MFCC	1.0%	1.0%
Transitional Case Management, HCBS Waiver-RN	1.0%	1.0%
Transitional Case Management, HHA	1.0%	1.0%
Transitional Case Management, Professional Corporation	5.0%	5.0%
Utility Coverage, HCBS Benefit Provider-LCSW	5.0%	5.0%
Utility Coverage, HCBS Benefit Provider-Licensed Psychologists	5.0%	5.0%
Utility Coverage, HCBS Benefit Provider-MFCC	5.0%	5.0%
Utility Coverage, HCBS Waiver-RN	15.0%	15.0%
Utility Coverage, HHA	20.0%	20.0%
Utility Coverage, Professional Corporation	5.0%	5.0%
Waiver Service Coordination, HCBS Benefit Provider-LCSW	1.0%	1.0%
Waiver Service Coordination, HCBS Benefit Provider-Licensed Psychologist	1.0%	1.0%
Waiver Service Coordination, HCBS Benefit Provider-MFCC	1.0%	1.0%
Waiver Service Coordination, HCBS Waiver-RN	5.0%	5.0%
Waiver Service Coordination, HHA	5.0%	5.0%
Waiver Service Coordination, Professional Corporation	1.0%	1.0%

Cost Factor Assumptions

- Environmental Accessibility Adaptations services are capped at a lifetime cost of $5,000.00.
- Rates of reimbursements for waiver and State Plan services are projected to increase two percent each waiver year, consistent with the current California Consumer Price Index for medical services, providing the appropriate State of California funding authorities approve the increases.
- Utility Coverage will be provided to waiver beneficiaries, who are dependent upon medical technology. Life sustaining medical equipment is limited to the following: mechanical ventilation equipment and other respiratory therapy equipment, suction machines, cardiorespiratory monitors, feeding pumps, and infusion equipment.
- Utility coverage is limited to that portion of the utility bills directly attributable to operation of life sustaining medical equipment in the beneficiary's place of residence. The minimum monthly amount of reimbursement will be $20.00 a month with a maximum monthly amount of $75.00. For purposes of completing Appendix G-2, an average of $45.00 and is based on historical data.
- Projected individual rates of utilization of IHMC Waiver services are expected to remain constant over the five-year approval period.
- Average waiver length of stay is expected to remain constant over the five-year approval period.
- Projection for services not previously offered are based on expenditures and utilization of comparable services offered through MCOD's other HCBS waivers.
- Waiver beneficiaries under 21 years of age will first utilize State Plan services, such as EPSDT when available, before IHMC Waiver services to meet their needs.

APPENDIX G-2 (cont.)Demonstration of Factor D estimates

Level of Care: Hospital

Waiver Year 1: 2003/2004

Waiver Services	Unduplicated Users	Avg. Annual Units/Users	Avg. Unit Cost	Total
Case Management - HHA	166	48 hours	$45.43	$361,986
Case Management - Individual Nurse Provider	9	1 hours	$35.77	$322
Case Management - Individual Licensed Professional	4	1 hours	$35.77	$143
Case Management - Professional Organization	2	1 hours	$45.43	$91
Waiver Service Coordination	2	8 hours	$35.77	$572
Respite INP - LVN	2	40 hours	$24.42	$1,954
Respite HHA - LVN	2	40 hours	$29.41	$2,353
Transitional Case Management Services	66	40 hours	$45.43	$119,935
CLHF - Private Duty Nursing Services – RN/LVN/CNA	26	365 days	$490.60	$4,655,794
Environmental Accessibility Adaptations	10	1 event	$5,000.00	$50,000
PERS	6	1 months	$31.51	$189
Private Duty Nursing - RN - HA	40	7,900 hours	$40.57	$12,820,120
Private Duty Nursing -RN - HHA - Shared	20	500 hours	$44.63	$446,300
Private Duty Nursing - RN - INP	10	1,000 hours	$31.94	$319,400
Private Duty Nursing - RN - INP - Shared	2	500 hours	$35.13	$35,130
Private Duty Nursing - RN - INP - Supervision	10	24 hours	$35.77	$8,585
Private Duty Nursing - LVN - HHA	180	5,760 hours	$29.41	$30,492,288
Private Duty Nursing - LVN - HHA-Shared	2	300 hours	$32.35	$19,410
Private Duty Nursing - LVN - INP	10	250 hours	$24.42	$61,050
Private Duty Nursing - LVN - INP- Shared	2	125 hours	$26.86	$6,715
Home Health Aide Services CHHA - HHA	20	800 hours	$18.90	$302,400
Home Health Aide Services CHHA - HHA- Shared	2	400 hours	$20.79	$16,632
Family Training - HHA	10	24 hours	$45.43	$10,903
Family Training - RN - INP	2	24 hours	$35.77	$1,717
Grand Total				$49,733,989

Waiver Services	Unduplicated Users	Avg. Annual Units/Users	Avg. Unit Cost	Total
Number of estimated unduplicated uses				200

Factor D:	$248,670
Factor D':	$35,202
Total	$283,872
Factor G:	$305,283
Factor G':	$8,773
Total	$314,056
Average number of days:	**319**

APPENDIX G-2 (cont.)Demonstration of Factor D estimates

Level of Care: Hospital

Waiver Year 2: 2004/2005

Waiver Services	Unduplicated Users	Avg. Annual Units/Users	Average Unit Cost	Total
Case Management - HHA	207	48 hours	$46.79	$464,905
Case Management - Individual Nurse Provider	11	1 hours	$36.84	$405
Case Management - Individual Licensed Professional	5	1 hours	$36.84	$184
Case Management - Professional Organization	2	1 hours	$46.79	$91
Waiver Service Coordination	3	8 hours	$36.84	$884
Respite INP – LVN	3	40 hours	$25.15	$3,018
Respite HHA – LVN	3	40 hours	$30.29	$3,635
Transitional Case Management Services	83	40 hours	$46.79	$155,343
CLHF - Private Duty Nursing Services – RN/LVN/CAN	33	365 days	$505.32	$6,086,579
Environmental Accessibility Adaptations	13	1 event	$5,000.00	$65,000
PERS	8	1 months	$32.46	$260
Private Duty Nursing - RN - HA	50	7,900 hours	$41.79	$16,507,050
Private Duty Nursing -RN - HHA - Shared	25	500 hours	$45.97	$574,625
Private Duty Nursing - RN - INP	13	1,000 hours	$32.90	$427,700
Private Duty Nursing - RN - INP - Shared	3	500 hours	$36.18	$54,270
Private Duty Nursing - RN - INP - Supervision	13	24 hours	$36.84	$11,494
Private Duty Nursing - LVN - HHA	225	5,760 hours	$30.29	$39,255,840
Private Duty Nursing - LVN - HHA-Shared	3	300 hours	$33.32	$29,988
Private Duty Nursing - LVN - INP	13	250 hours	$25.15	$81,738
Private Duty Nursing - LVN - INP- Shared	3	125 hours	$27.67	$10,376
Home Health Aide Services CHHA - HHA	25	800 hours	$19.47	$389,400
Home Health Aide Services CHHA - HHA- Shared	3	400 hours	$21.41	$25,692
Family Training - HHA	13	24 hours	$46.79	$14,598
Family Training - RN - INP	3	24 hours	$36.84	$2,652
Grand Total				$64,165,731

Waiver Services	Unduplicated Users	Avg. Annual Units/Users	Average Unit Cost	Total
Number of estimated unduplicated uses				250

Factor D: $256,663

Factor D': $36,258

Total $292,921

Factor G: $322,422

Factor G': $9,036

Total **$331,458**

Average number of days: **327**

APPENDIX G-2 (cont.)**Demonstration of Factor D estimates:**

Level of Care: Hospital

Waiver Year 3: 2005/2006

Waiver Service	Average Unduplicated Users	Average Annual Units/User	Average Unit Cost	Total
Case Management, HCBS Benefit Provider-LCSW	5.4	48 hours	$35.77	$9,271.58
Case Management, HCBS Benefit Provider-Licensed Psychologist	5.4	48 hours	$35.77	$9,271.58
Case Management, HCBS Benefit Provider-MFCC	5.4	48 hours	$35.77	$9,271.58
Case Management, HCBS Waiver-RN	13.5	48 hours	$35.77	$23,178.96
Case Management, HHA-RN	216.0	48 hours	$45.43	$471,018.24
Case Management, Professional Corporation	5.4	48 hours	$45.43	$11,775.46
Environmental Accessibility Adaptations	15.0	1 event	$5,000.00	$75,000.00
Family Training, HCBS Waiver-RN	6.0	48 hours	$35.77	$10,301.76
Family Training, HHA	11.7	48 hours	$45.43	$25,513.49
Personal Emergency Response System	18.0	12 months	$31.51	$6,806.16
Private Duty Nursing, HCBS Nursing Facility (CLHF)	54.0	365 days	$490.60	$9,669,726.00
Private Duty Nursing, HCBS Waiver-LVN	27.0	6000 hours	$24.92	$4,037,040.00
Private Duty Nursing, HCBS Waiver-LVN, Shared	5.4	4000 hours	$26.86	$580,176.00
Private Duty Nursing, HCBS Waiver-RN	13.5	6000 hours	$31.94	$2,587,140.00
Private Duty Nursing, HCBS Waiver-RN, Shared	5.4	4000 hours	$35.13	$758,808.00
Private Duty Nursing, HCBS Waiver-RN, Supervision	27.0	48 hours	$35.77	$46,357.92
Private Duty Nursing, HHA-CHHA	162.0	300 hours	$18.90	$918,540.00
Private Duty Nursing, HHA-CHHA, Shared	5.4	300 hours	$20.79	$33,679.80
Private Duty Nursing, HHA-LVN	162.0	6000 hours	$29.41	$28,586,520.00
Private Duty Nursing, HHA-LVN, Shared	5.4	4000 hours	$32.35	$698,760.00
Private Duty Nursing, HHA-RN	27.0	6000 hours	$40.57	$6,572,340.00
Private Duty Nursing, HHA-RN, Shared	5.4	4000 hours	$44.63	$964,008.00
Respite, Acute Care Hospital	3.0	7 days	$1,029.00	$21,609.00
Respite, HCBS Nursing Facility (CLHF)	5.7	7 days	$490.60	$19,574.94
Respite, HCBS Waiver-LVN	3.0	56 hours	$24.42	$4,102.56
Respite, HCBS Waiver-RN	3.0	56 hours	$31.94	$5,365.92
Respite, HHA-CHHA	3.0	56 hours	$18.90	$3,175.20
Respite, HHA-LVN	3.0	56 hours	$29.41	$4,940.88
Respite, HHA-RN	3.0	56 hours	$40.57	$6,815.76
Transitional Case Management, HCBS Benefit Provider-LCSW	3.0	48 hours	$35.77	$5,150.88
Transitional Case Management, HCBS Benefit Provider-Licensed Psychologist	3.0	48 hours	$35.77	$5,150.88

Waiver Service	Average Unduplicated Users	Average Annual Units/User	Average Unit Cost	Total
Transitional Case Management, HCBS Benefit Provider-MFCC	3.0	48 hours	$35.77	$5,150.88
Transitional Case Management, HCBS Waiver-RN	3.0	48 hours	$35.77	$5,150.88
Transitional Case Management, HHA	3.0	48 hours	$45.43	$6,541.92
Transitional Case Management, Professional Corporation	15.0	48 hours	$45.43	$32,709.60
Utility Coverage, HCBS Benefit Provider-LCSW	15.0	12 months	$45.00	$8,100.00
Utility Coverage, HCBS Benefit Provider-Licensed Psychologists	15.0	12 months	$45.00	$8,100.00
Utility Coverage, HCBS Benefit Provider-MFCC	15.0	12 months	$45.00	$8,100.00
Utility Coverage, HCBS Waiver-RN	45.0	12 months	$45.00	$24,300.00
Utility Coverage, HHA	60.0	12 months	$45.00	$32,400.00
Utility Coverage, Professional Corporation	15.0	12 months	$45.00	$8,100.00
Waiver Service Coordination, HCBS Benefit Provider-LCSW	3.0	48 hours	$35.77	$5,150.88
Waiver Service Coordination, HCBS Benefit Provider-Licensed Psychologist	3.0	48 hours	$35.77	$5,150.88
Waiver Service Coordination, HCBS Benefit Provider-MFCC	3.0	48 hours	$35.77	$5,150.88
Waiver Service Coordination, HCBS Waiver-RN	15.0	48 hours	$35.77	$25,754.40
Waiver Service Coordination, HHA	15.0	48 hours	$45.43	$32,709.60
Waiver Service Coordination, Professional Corporation	3.0	48 hours	$45.43	$6,541.92
Grand Total:				**$56,399,502.40**
Enrollment Cap:				**300**
Factor D:				**$187,998**
Average Length of Stay (days):				**300**

APPENDIX G-2 (cont.)**Demonstration of Factor D estimates:**

Level of Care: Hospital

Waiver Year 4: 2006/2007

Waiver Service	Average Unduplicated Users	Average Annual Units/User	Average Unit Cost	Total
Case Management, HCBS Benefit Provider-LCSW	6.3	48 hours	$36.49	$11,034.58
Case Management, HCBS Benefit Provider-Licensed Psychologist	6.3	48 hours	$36.49	$11,034.58
Case Management, HCBS Benefit Provider-MFCC	6.3	48 hours	$36.49	$11,034.58
Case Management, HCBS Waiver-RN	15.8	48 hours	$36.49	$27,586.44
Case Management, HHA-RN	252.0	48 hours	$46.34	$560,528.64
Case Management, Professional Corporation	6.3	48 hours	$46.34	$14,013.22
Environmental Accessibility Adaptations	17.5	1 event	$5,000.00	$87,500.00
Family Training, HCBS Waiver-RN	7.0	48 hours	$36.49	$12,260.64
Family Training, HHA	13.7	48 hours	$46.34	$30,361.97
Personal Emergency Response System	21.0	12 months	$32.14	$8,099.28
Private Duty Nursing, HCBS Nursing Facility (CLHF)	63.0	365 days	$500.41	$11,506,927.95
Private Duty Nursing, HCBS Waiver-LVN	31.5	6000 hours	$25.42	$4,804,380.00
Private Duty Nursing, HCBS Waiver-LVN, Shared	6.3	4000 hours	$27.40	$690,480.00
Private Duty Nursing, HCBS Waiver-RN	15.8	6000 hours	$32.58	$3,078,810.00
Private Duty Nursing, HCBS Waiver-RN, Shared	6.3	4000 hours	$35.83	$902,916.00
Private Duty Nursing, HCBS Waiver-RN, Supervision	31.5	48 hours	$36.49	$55,172.88
Private Duty Nursing, HHA-CHHA	189.0	300 hours	$19.28	$1,093,176.00
Private Duty Nursing, HHA-CHHA, Shared	6.3	300 hours	$21.21	$40,086.90
Private Duty Nursing, HHA-LVN	189.0	6000 hours	$30.00	$34,020,000.00
Private Duty Nursing, HHA-LVN, Shared	6.3	4000 hours	$33.00	$831,600.00
Private Duty Nursing, HHA-RN	31.5	6000 hours	$41.38	$7,820,820.00
Private Duty Nursing, HHA-RN, Shared	6.3	4000 hours	$45.52	$1,147,104.00
Respite, Acute Care Hospital	3.5	7 days	$1049.58	$25,714.71
Respite, HCBS Nursing Facility (CLHF)	6.7	7 days	$500.41	$23,294.09
Respite, HCBS Waiver-LVN	3.5	56 hours	$24.91	$4,882.36
Respite, HCBS Waiver-RN	3.5	56 hours	$32.58	$6,385.68
Respite, HHA-CHHA	3.5	56 hours	$19.28	$3,778.88
Respite, HHA-LVN	3.5	56 hours	$30.00	$5,880.00
Respite, HHA-RN	3.5	56 hours	$41.38	$8,110.48
Transitional Case Management, HCBS Benefit Provider-LCSW	3.5	48 hours	$36.49	$6,130.32
Transitional Case Management, HCBS Benefit Provider-Licensed Psychologist	3.5	48 hours	$36.49	$6,130.32
Transitional Case Management, HCBS Benefit Provider-MFCC	3.5	48 hours	$36.49	$6,130.32

Waiver Service	Average Unduplicated Users	Average Annual Units/User	Average Unit Cost	Total
Transitional Case Management, HCBS Waiver-RN	3.5	48 hours	$36.49	$6,130.32
Transitional Case Management, HHA	3.5	48 hours	$46.34	$7,785.12
Transitional Case Management, Professional Corporation	17.5	48 hours	$46.34	$38,925.60
Utility Coverage, HCBS Benefit Provider-LCSW	17.5	12 months	$45.90	$9,639.00
Utility Coverage, HCBS Benefit Provider-Licensed Psychologists	17.5	12 months	$45.90	$9,639.00
Utility Coverage, HCBS Benefit Provider-MFCC	17.5	12 months	$45.90	$9,639.00
Utility Coverage, HCBS Waiver-RN	52.5	12 months	$45.90	$28,917.00
Utility Coverage, HHA	70.0	12 months	$45.90	$38,556.00
Utility Coverage, Professional Corporation	17.5	12 months	$45.90	$9,639.00
Waiver Service Coordination, HCBS Benefit Provider-LCSW	3.5	48 hours	$36.49	$6,130.32
Waiver Service Coordination, HCBS Benefit Provider-Licensed Psychologist	3.5	48 hours	$36.49	$6,130.32
Waiver Service Coordination, HCBS Benefit Provider-MFCC	3.5	48 hours	$36.49	$6,130.32
Waiver Service Coordination, HCBS Waiver-RN	17.5	48 hours	$36.49	$30,651.60
Waiver Service Coordination, HHA	17.5	48 hours	$46.34	$38,925.60
Waiver Service Coordination, Professional Corporation	3.5	48 hours	$46.34	$7,785.12
Grand Total:				**$67,115,988.12**
Enrollment Cap:				**350**
Factor D:				**$191,760**
Average Length of Stay (days):				**300**

APPENDIX G-2 (cont.)**Demonstration of Factor D estimates:**

Level of Care: Hospital

Waiver Year 5: 2007/2008

Waiver Service	Average Unduplicated Users	Annual Units/User	Average Unit Cost	Total
Case Management, HCBS Benefit Provider-LCSW	7.2	48 hours	$37.22	$12,863.23
Case Management, HCBS Benefit Provider-Licensed Psychologist	7.2	48 hours	$37.22	$12,863.23
Case Management, HCBS Benefit Provider-MFCC	7.2	48 hours	$37.22	$12,863.23
Case Management, HCBS Waiver-RN	18.0	48 hours	$37.22	$32,158.08
Case Management, HHA-RN	288.0	48 hours	$47.27	$653,460.48
Case Management, Professional Corporation	7.2	48 hours	$47.27	$16,336.51
Environmental Accessibility Adaptations	20.0	1 event	$5,000.00	$100,000.00
Family Training, HCBS Waiver-RN	8.0	48 hours	$37.22	$14,292.48
Family Training, HHA	15.6	48 hours	$47.27	$35,395.78
Personal Emergency Response System	24.0	12 months	$32.78	$9,440.64
Private Duty Nursing, HCBS Nursing Facility (CLHF)	72.0	365 days	$510.42	$13,413,837.60
Private Duty Nursing, HCBS Waiver-LVN	36.0	6000 hours	$25.93	$5,600,880.00
Private Duty Nursing, HCBS Waiver-LVN, Shared	7.2	4000 hours	$27.95	$804,960.00
Private Duty Nursing, HCBS Waiver-RN	18.0	6000 hours	$33.23	$3,588,840.00
Private Duty Nursing, HCBS Waiver-RN, Shared	7.2	4000 hours	$36.55	$1,052,640.00
Private Duty Nursing, HCBS Waiver-RN, Supervision	36.0	48 hours	$37.22	$64,316.16
Private Duty Nursing, HHA-CHHA	216.0	300 hours	$19.67	$1,274,616.00
Private Duty Nursing, HHA-CHHA, Shared	7.2	300 hours	$21.63	$46,720.80
Private Duty Nursing, HHA-LVN	216.0	6000 hours	$30.60	$39,657,600.00
Private Duty Nursing, HHA-LVN, Shared	7.2	4000 hours	$33.66	$969,408.00
Private Duty Nursing, HHA-RN	36.0	6000 hours	$42.21	$9,117,360.00
Private Duty Nursing, HHA-RN, Shared	7.2	4000 hours	$46.43	$1,337,184.00
Respite, Acute Care Hospital	4.0	7 days	$1070.57	$29,975.96
Respite, HCBS Nursing Facility (CLHF)	7.6	7 days	$510.42	$27,154.34
Respite, HCBS Waiver-LVN	4.0	56 hours	$25.41	$5,691.84
Respite, HCBS Waiver-RN	4.0	56 hours	$33.23	$7,443.52
Respite, HHA-CHHA	4.0	56 hours	$19.67	$4,406.08
Respite, HHA-LVN	4.0	56 hours	$30.60	$6,854.40
Respite, HHA-RN	4.0	56 hours	$42.21	$9,455.04
Transitional Case Management, HCBS Benefit Provider-LCSW	4.0	48 hours	$37.22	$7,146.24
Transitional Case Management, HCBS Benefit Provider-Licensed Psychologist	4.0	48 hours	$37.22	$7,146.24

Waiver Service	Average Unduplicated Users	Average Annual Units/User	Average Unit Cost	Total
Transitional Case Management, HCBS Benefit Provider-MFCC	4.0	48 hours	$37.22	$7,146.24
Transitional Case Management, HCBS Waiver-RN	4.0	48 hours	$37.22	$7,146.24
Transitional Case Management, HHA	4.0	48 hours	$47.27	$9,075.84
Transitional Case Management, Professional Corporation	20.0	48 hours	$47.27	$45,379.20
Utility Coverage, HCBS Benefit Provider-LCSW	20.0	12 months	$46.82	$11,236.80
Utility Coverage, HCBS Benefit Provider-Licensed Psychologists	20.0	12 months	$46.82	$11,236.80
Utility Coverage, HCBS Benefit Provider-MFCC	20.0	12 months	$46.82	$11,236.80
Utility Coverage, HCBS Waiver-RN	60.0	12 months	$46.82	$33,710.40
Utility Coverage, HHA	80.0	12 months	$46.82	$44,947.20
Utility Coverage, Professional Corporation	20.0	12 months	$46.82	$11,236.80
Waiver Service Coordination, HCBS Benefit Provider-LCSW	4.0	48 hours	$37.22	$7,146.24
Waiver Service Coordination, HCBS Benefit Provider-Licensed Psychologist	4.0	48 hours	$37.22	$7,146.24
Waiver Service Coordination, HCBS Benefit Provider-MFCC	4.0	48 hours	$37.22	$7,146.24
Waiver Service Coordination, HCBS Waiver-RN	20.0	48 hours	$37.22	$35,731.20
Waiver Service Coordination, HHA	20.0	48 hours	$47.27	$45,379.20
Waiver Service Coordination, Professional Corporation	4.0	48 hours	$47.27	$9,075.84
Grand Total:				**$78,237,287.17**
Enrollment Cap:				**400**
Factor D:				**$195,593**
Average Length of Stay (days):				**300**

Appendix G-3, Methods Used to Exclude Payments for Room and Board

Methods Used to Exclude Payments for Room and Board

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

"Not applicable"

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

"Not applicable"

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Appendix G-4, Methods Used to Make Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Methods Used to Make Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

___ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

Appendix G-5, Factor D'

Level of Care: Hospital

NOTICE: On July 25, 1994, HCFA published regulations ***that*** changed the definition of Factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The costs of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

Waiver services to users under the age of 21 years are only those services not covered under the authority of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services program pursuant to Section 1905(r) of the Social Security Act (refer to page 2-a).

Appendix G-5 (Cont.)

Factor D'

Level of Care: Hospital

Factor D' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

__X__ Based on HCFA Form 372 for years 07/01/02 – 06/31/03 and 07/01/03 – 06/30/04 of waiver # 0348.90.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify): The costs for durable medical equipment (DME) are not included in any waiver rate whereas DME costs are included as part of the long term care rate in the hospital setting.

It is expected that the majority of patients served in the waiver will be have a need for some type of DME.

The amended Waiver Year 3 Factor D' is $36,805. A cost of living adjustment of two percent is added to the projections for Waiver Years 4 and 5.

Appendix G-6, Factor G

Factor G

Level of Care: Hospital

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

__X__ Based on trends shown by HCFA Form 372 for the period 07/01/02-06/31/03 and 07/01/03-06/30/04 of waiver # 0348.90, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__X__ Other (specify): If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

The average acute care hospital rate for the year ending December 1, 2003 is $1,029. A cost of living adjustment of two percent is added to the projections for Waiver Years 4 and 5.

Appendix G-7, Factor G'

Factor G'

Level of Care: Hospital

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If individual respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

_X_ Based on HCFA Form 372 the period 07/01/02-06/31/03 and 07/01/03-06/30/04 of waiver # 0348.90.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_X_ Other (specify): The amended Waiver Year 3 Factor G' is $39,324. A cost of living adjustment of two percent is added to the projections for Waiver Years 4 and 5.

Appendix G-8, Demonstration of Cost Neutrality

Demonstration of Cost Neutrality

Level of Care: Hospital

Year 1: 2003/2004				
Factor D:	$248,670		**Factor G:**	$305,283
Factor D':	$35,202		**Factor G':**	$8,773
Total:	**$283,872**	≤	**Total:**	**$314,056**
Year 2: 2004/2005				
Factor D:	$256,663		**Factor G:**	$322,422
Factor D':	$36,258		**Factor G':**	$9,036
Total:	**$292,921**	≤	**Total:**	**$331,458**
Year 3: 2005/2006				
Factor D:	$187,998		**Factor G:**	$450,114
Factor D':	$36,805		**Factor G':**	$39,324
Total:	**$224,803**	≤	**Total:**	**$489,438**
Year 4: 2006/2007				
Factor D:	$191,760		**Factor G:**	$459,116
Factor D':	$37,541		**Factor G':**	$40,110
Total:	**$229,301**	≤	**Total:**	**$499,227**
Year 5: 2007/2008				
Factor D:	$195,593		**Factor G:**	$468,299
Factor D':	$38,292		**Factor G':**	$40,913
Total:	**$233,885**	≤	**Total:**	**$509,211**